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*Hansson, K. G., Body Mechanics and Posture, J.A.M.A. 128:947 (July 28) 1945.

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Between Ourselves

Third vice-president of the ***Canadian Nurses' Association,*** **Alice Girard** brings us an interesting summary of a very busy conference week in which she participated last December. The primary purpose of this get-together of outstanding leaders in public health was to assess the present situation in so far as care of the sick in their homes is concerned. Building on the information thus accumulated, a blueprint for future activity was sketched without pausing to develop details.

Completely bilingual, Miss Girard, who was born and educated in the United States, graduated from St. Vincent de Paul Hospital in Sherbrooke, Que. She secured her certificate in public health nursing from the School of Nursing, University of Toronto. Later she qualified for her Bachelor of Science degree at the Catholic University of America, Washington, D.C.; she received her Master of Arts from Teachers College, Columbia University, in 1944. She has been superintendent of nursing services of the Metropolitan Life Insurance Company in Canada since 1947. Previously she was director of the School for Public Health Nursing, University of Montreal.

* * *

The nurses in the Trail Chapter of the R.N.A.B.C. have been fortunate this year in having an interesting, stimulating and informative series of lectures delivered to them by **Dr. A. F. Alvarez.** We are very happy that the papers from this series have been made available to us to share with all the nurses of Canada. The first of these, dealing with the very pertinent topic of the ***maintenance of fluid balance*** in times of illness, appears in this issue.

* * *

Within recent months committees appointed by the provincial nurses' associations have been conscientiously engaged in making active studies of the subject matter included in the ***curricula of our schools of nursing.*** There is a recognized need that such studies should be made in order that our nursing students may be kept abreast of all the latest developments in medical science and nursing service.

An understanding of the philosophy that is basic to contemplated revisions is not only necessary but is also a requisite if these committees are to avoid certain pitfalls that may result from an exigent demand and mounting pressure to get something accomplished. The exceedingly thoughtful discussion of this underlying philosophy, prepared for us by **Norena Mackenzie,** might well become required reading for all committee members, all instructors—active and potential—in fact for everyone concerned with the education of nurses. We heartily recommend it to you.

* * *

At the 54th annual meeting of the Board of Governors of the Victorian Order of Nurses for Canada, held in Ottawa last year, the guest speaker was **Ruth Freeman,** well known to public health nurses through the sterling calibre of her books in this field. We are very pleased that we are able to bring her address to you. There is much that ties in with the findings reported in our guest editorial. We hope that the staffs in our schools of nursing will read this article, too, so that all of us may be aware of current trends in the ***home care of illness.***

* * *

A gradual awakening to the importance of providing some form of employment for older age group citizens is evident in many parts of our country and elsewhere. For so long we have concentrated on the basic needs of children—their need for a feeling of security, for an opportunity of self-expression, for some evidence of our appreciation of their efforts. Today we are coming to a realization that so many of the older men and women in our communities have the same needs.

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Administration—*Cream:* Local application with applicator. *Suppositories:* 1 to 3 suppositories daily, according to physician's advice.

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Manufacturer—Winthrop-Stearns of Canada Ltd., Windsor, Ont.

Description—Each tablet contains: 0.25 gm. aluminum hydroxide geldried; 0.45 gm. magnesium trisilicate, pleasantly flavored.

Indications—Gastric hyperacidity, peptic ulcer.

Administration—In peptic ulcer, 2 tablets every 2 hours. As an antacid, 1 or 2 tablets about one hour after meals or every 2 to 4 hours and at bedtime if necessary. For best effect, a half-hour should elapse before fluids are taken.

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Indications—For replacement of electrolytes lost in gastric fluid through gastric suction or vomiting; also provides dextrose.

Administration—Intravenously at a rate not to exceed 500 cc. per hour. Excess glycosuria is avoided by infusing at a rate not exceeding 0.6 gm. dextrose per kg. body weight per hour.

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Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Electrolyte Solution D. Each 100 cc. of sterile solution contains: Dextrose U.S.P. 10.0 gm., sodium chloride 0.51 gm. (8.8 mEq.) potassium chloride 0.09 gm. (1.2 mEq.), sodium lactate 0.56 gm., (5.0 mEq.).

Indications—For replacement of electrolytes lost in duodenal fluid through intestinal suction or biliary or pancreatic drainage. Also provides dextrose in same solution.

Administration—Intravenously at a rate not to exceed 500 cc. per hour. Excess glycosuria is avoided by infusing at a rate not exceeding 0.6 gm. of dextrose per kilogram of body weight per hour.

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1. Perloff, W. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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Public Health Nursing Tomorrow

WILL THE PUBLIC health nursing agencies of tomorrow be combined agencies giving complete public health nursing care? Will prepaid medical care plans include nursing care of the sick in their homes? Will the hospitals develop home nursing service programs? These and many other similar questions were being raised and discussed by a group of representatives of official and voluntary public health nursing agencies meeting during the week of December 1, 1952, at Arden House on the Harriman Campus of Columbia University.

The purpose of this conference was to determine ways in which the needs of sick people in their homes could be met through public health nursing services, and the organization, administration and coordination of these services in the community.

Approximately 90 delegates, most of them executives in their respective agencies, met for four days either in general sessions or in work groups. Group leaders and recorders were responsible for the reports which were drawn up after each meeting and presented at the general sessions. This method allowed all the members the opportunity to participate actively in the discussions, to share their problems, and to pool their opinions and experiences.

It was recognized early in these meetings that there are many changes affecting the nature of the needs for nursing services today. Social changes, technological advances, early ambula-

ALICE GIRARD

tion, newer treatments, and new approaches to rehabilitation have brought about an increase in the number and kinds of nursing services needed. For social as well as economic reasons, there is a growing tendency to focus more of these services in the home where the family represents the logical social unit for receipt of these services.

It was felt that the term "bedside nursing" is no longer adequate to describe nursing care of the sick. In recent years, qualitative as well as quantitative changes in nursing care have occurred which need to be considered. Palliative, restorative and rehabilitation service with instruction in health promotion, prevention of disease and psychological support for the whole family should be provided in the home.

Although members of the conference agreed that most communities already possess many of the tools necessary to analyze their changing needs for nursing services, they did not fail to take cognizance of difficulties which stand in the way of meeting those needs and which often block the best use of community resources in solving recognized problems. Certain attitudes and a fear of change often influence the acceptance of necessary actions essential to the carrying out of the objectives. Some physicians are still reluctant to accept the services of a nurse as an aid to the family, when the former is employed by an organized health agency. Agencies may be unwilling to accept the results of sound community plans if this means a change in operating established services. Nurses are also unwilling to change their activities when the scope of the agency broadens (official health agency nurses resist giving actual nursing care—voluntary agency nurses resist a merger). The multiplicity of agencies results in confusion to the family when nurses from different agencies visit the home. Gaps in service occur because of uncoordinated activities offered by different health and welfare agencies. Lack of skills in interpersonnel and interagency communication is frequent. Shortage of personnel and of financial support does exist although these are not insoluble problems.

If we accept the premise that, in general, a single nursing agency is preferable in order to provide better service to the patient and family, better use of personnel, and to avoid duplication and confusion, it seems that combined agencies giving complete generalized nursing service when and where the community is adequately equipped for and ready to support such a service may, in the future, be the best answer to the needs of the sick in their homes. In those communities where there are no agencies providing nursing service in the homes, the hospital might well be the logical organization to assume this responsibility but in no case should the home be a cheap substitute for the hospital. The primary objective of home care should be to serve the individual. The freeing of hospital beds and the professional education of doctors, nurses, and social workers should be secondary objectives. Therefore, the following factors must be considered in the selection of patients for home care:

The clinical condition of the patient (he must no longer require the specialized hospital facilities); the patient's desire to be cared for in the home; the psychological attitude of the family toward home care; the atmosphere and physical environment of the home; the distance between the home and the hospital.

Some attempts have been made in the past few years to include home nursing care in the programs of various health insurance plans. The participants agreed that even though the administrators of most prepaid medical insurance plans do not find it feasible at present to include nursing service in the home (because of the cost and allegedly because of the demand by the consumer for broader general hospital services), there is a need for instigating further experiments and research in this field.

The hope was expressed that the team concept would eventually permeate into the philosophy of those responsible for drawing up the policies and plans of the various agencies con-

cerned with the health and welfare of the community and that the team approach would help to solve many of these problems.

The ultimate goal in the care of the sick at home is a family centred service available to all people in the community. Public health nursing aims to assure this service through nursing care, education of the patient and family in relation to the patient's needs, aid in the promotion of independence for the family, and understanding and help in emotional adjustments to illness as well as appropriate use of community resources.

ALICE GIRARD
Third Vice-President
Canadian Nurses' Association

The Maintenance of Fluid Balance

A. F. ALVAREZ, M.B., CH.B., F.R.C.S. (ENG.)

THE IMPORTANT ROLE played by water in the human body may be deducted from the fact that it is responsible for no less than 70 per cent of the body weight. It may well be said that every one of our actions is carried out against a fluid background, for fluid is the medium by which our daily food is digested, assimilated, and transported to the myriad cells in need of constant nourishment. Substances for which the body has no further use, and which if retained could be harmful, are got rid of by the kidneys, bowel and lung to which they are carried in a fluid state. The thousand and one complicated physicochemical reactions which outwardly manifest themselves as life are carried out in solutions, the nature of which permit the intimate contact between the reagents which is essential for their interaction.

Within the living organism, water is distributed into two main compartments—the intracellular and the extracellular. Intracellular water accounts for 50 per cent of the body weight, while the extracellular, which accounts for the remaining 20 per cent, is subdivided into "interstitial" fluid, the fluid within the tissue spaces around the cells (15%), and "intravascular" fluid, the circulating fluid present in the various vessels of the body (5%).

Water, however, is only one of the ingredients of the body fluids, for within it are dissolved diverse substances which are essential to life. In fact, water may be looked upon as the vehicle in which such vital substances are carried hither and thither, to perform their manifold activities. The term "electrolyte" is often used to denote some of these other ingredients because when they are in solution they split up into their essential components which exist as electrically charged particles or "ions"—"cations" when the charge is positive, "anions" when it is negative. For example, sodium chloride when dissolved becomes split up into the cation sodium (denoted as Na^+) and the anion chlorine (Cl^-). Positively charged particles exactly neutralize negatively charged ones so that in the body there is a constant electrical ionic balance.

The principal cations of importance in the study of fluid balance are sodium, potassium, magnesium, and calcium; the anions associated with them are chlorine, bicarbonate, phosphate, sulphate, various organic acids, and proteins. Although all these electro-

Dr. Alvarez is in the Department of Surgery, the C. S. Williams Clinic, Trail, B.C. This is the first of a series of lectures he has been giving to the nursing staff of the Trail-Tadanac Hospital.

lytes exist in both the intracellular and the extracellular fluid, their individual concentration varies from one fluid to the other.

Under normal conditions of health the concentration of electrolytes in these fluid solutions is remarkably constant. Alterations in the water content of the body will, however, change the concentration of such substances and so will an abnormally large intake or loss of the substances themselves. In thirst and excessive sweating there is a deficiency of water which results in the concentration of electrolytes, particularly sodium chloride. In vomiting, besides water there is a loss of sodium chloride and, to a lesser extent, of potassium and other ions. In diarrhea an important deficiency of sodium bicarbonate may be caused. Important water and electrolyte changes may also be caused by discharging fistulae such as those following injury to the duodenum, pancreas, and biliary tract.

On the other hand increased concentrations of electrolytes may result from their excessive intake as, for example, alkalis in over-assiduous medication of peptic ulcers or from impairments in their normal excretion as is the case in uremia.

At first, the brunt of such changes is borne by the extracellular fluid but later the intracellular fluid also suffers, for compensatory rearrangements take place in their own electrolyte content and their structure becomes so altered that the cells can no longer act satisfactorily and their action is impaired. If the situation is unrelieved the cells cease to function altogether. If a sufficiently large number of important cells is thus affected the body as a whole fails, death being the end result,

Where the concentration of any given ion is greatly decreased its place is taken by other ions carrying the same kind of electric charge so as to maintain the previously referred to electrical balance, and maintain the osmotic pressure of the fluids as close to normal as possible. According to the nature of the ion that is lost and that which takes its place the reaction of the blood may change so that either alkalosis or acidosis may follow. Thus, in excessive vomiting, the body compensates for the loss of chloride by increasing the dissociation of sodium bicarbonate, that is, increasing the concentration of bicarbonate ions and, as these are essentially basic in their reaction, a condition of alkalosis develops. On the other hand, in some cases of diarrhea the loss of bicarbonate is compensated by the acid chloride ions and acidosis is the result. In renal failure, the kidneys may fail to secrete the acid phosphate and sulphate radicals which, therefore, reach abnormally large concentrations in the blood and again acidosis occurs.

It is clear that the maintenance of fluid balance is an all-important factor in the fight against disease. All lost fluid must be replaced. Such a restoration must be considered under three headings: (a) normal maintenance; (b) the compensation of fluid deficiencies; and (c) the replacement of abnormal losses.

Normal Maintenance

Under normal conditions the fluid lost by the body in each 24 hours is approximately 3,200 cc. which is distributed as follows:

Urine	1,500 cc.
Feces	200 cc.
Lungs & sweat	1,500 cc.
	3,200 cc.

The water thus lost by the body is normally made up by drinking the various beverages of ordinary life while the electrolytes contained in those fluids are largely derived from the diet. In hot climates, in excessive exercise, and in the febrile patient, the imperceptible loss by the lungs and the skin may become very much greater than the 1,500 cc. shown in the table. On the other hand, in the afebrile patient who is resting in bed, the metabolic activities are greatly decreased all round and the total fluid loss in 24 hours may be much less than 3,200 cc.

Compensation

The gross alteration in water and electrolyte content which may be

caused by vomiting, diarrhea, and other pathological conditions has already been referred to but an illustration of the extent of the fluid losses involved each 24 hours is well worthwhile and is provided by the following table:

Pyloric obstruction	1-2,000 cc.
Gastric suction	1-2,000 cc.
Diarrhea	2-4,000 cc.
Acute small intestinal obstruction	4-7,000 cc.

The detection of the presence and extent of such deficiencies must be prompt so that they can be corrected early, before the intracellular fluid and the cells themselves are seriously affected.

Replacement of Abnormal Losses

Abnormal fluid losses should be recognized at the very beginning so that they can be corrected soon, or even anticipated, and the damage that could have been caused eliminated from the very start.

In the less acute forms of dehydration and of electrolyte deficiencies the deleterious effects may only make themselves felt in an insidious, slowly progressive manner. Special tests are then usually made to expose such a state of affairs. Under such circumstances it is customary to determine the concentration of various substances in the more readily available fluids of the body, as for example the urine and blood. In the urine it is usual to measure the specific gravity (an indirect measurement of concentration), the concentration of urea and, if any is present, that of protein (usually reported as "albumin").

In the blood, routine assays are made of the concentration of urea, non-protein nitrogen, sodium chloride, and proteins. Under special circumstances further assays are made in connection with the alkali reserve, the potassium content, and the distribution of protein in the form of albumin and globulin. It is worthy of note that sodium chloride deficiencies may only become manifest in the blood stream at a relatively late stage, often much later than is the case in the urine.

The determination of the chloride content of the urine is rapid and easy and can be carried out with sufficient accuracy as a ward test. With us it is a routine practice that is carried out for the first few days after all major operations. It has been found to be of very great assistance and it has saved both the patient and the laboratory much needless blood work.

The maintenance of an adequate intake-output chart by the nursing staff is an essential safeguard where abnormal fluid losses exist, be it by vomiting, diarrhea, the presence of fistulae, ileostomies, etc. In the opposite direction it is important to detect abnormal fluid retention, as in cases of renal and cardiac edema and in excessive "drip" therapy; this will be suspected if the output is found to be short in comparison with the intake. Many adequate types of intake-output charts exist which provide a reliable record of the externally observable fluid transactions of the body. The one depicted herewith has been found to be efficient and it is reproduced purely for purposes of illustration. It is not claimed to be superior to any other.

The chart is self-explanatory but certain comments must be made regarding the proper usage of this and other similar records. In the first place it should be noted that *the chart belongs at the patient's bedside*, not in some remote, obscure corner where it is more likely to be forgotten than used at the right time—every time a fresh drink is poured, an infusion bottle is changed or urine is voided and measured. A cellophane cover, easily made from old x-ray films, will make a convenient cover and afford protection from spilt fluids.

Entries upon the chart should be clearly made together with a short pertinent description of the fluids that are aspirated. Such an hourly recording provides an invaluable guide to the progress of the patient. Thus in intestinal obstruction, to cite but one example, if the volume of fluid decreases and becomes more like bile in appearance all is going well, whereas if the volume gradually increases, the fluid becoming darker and its smell

Name: Mary Jones

INTAKE AND OUTPUT CHART

Date 10 Jan. 1953

TIME	INTAKE ORAL	INTAKE INTERSTITIAL	INTAKE I. V.	OUTPUT URINE	OUTPUT VOMIT	OUTPUT ASPIRATION
1 A.M.	—					
2	—					
3	—					
4	—					
5	—					
6	—					
7	—			15 oz.		
8	—					
9	—		1L. Blood			
10	—		↓			
11	—					10 cc. blood
12	—					5 " "
1 P.M.	—	1L. N/S				20 " "
2	—	↓				30 " "
3	—					10 " "
4	—					40 " "
5	—					5 " stale blood
6	—					5 " "
7	—	1L. 5% dextrose in water				50 " "
8	—	↓		8 oz. dark		60 " "
9	—					40 " "
10	—					25 " "
11	—					5 " "
12	—			23 oz.		0 " "
Total		2000 cc.	1000 cc.	690 cc.		305

Grand Total Intake 3,000 cc.
1,995

Total Output 995
If pyrectic add
If very pyrectic add (Operation) 1,000 cc.

Daily Fluid Balance 1,005 cc.

Date 11 Jan. 1953

Grand Total Output 1,995 cc.

1 A.M.	—					0
2	—	1L. N/S		10 oz. dark		10 cc. green
3	—	↓				50 " "
4	—					70 " "
5	—					100 " "
6	—					120 " brownish
7	—					110 " "
8	—					100 " "
9	30 cc.					40 " "
10	30			20 oz. clear		120 " brown
11	30					49 " "
12	30					66 " "
1 P.M.	30	1L. 5% dextrose in water				123 " "
2	30	↓				80 " "
3	30					70 " dark green
4	30					60 " "
5	30					55 " "
6	30			6 oz. clear		83 " "
7	30					42 " "
8	30					40 " "
9	30					52 " "
10	30			12 oz. clear		60 " green
11	30					50 " "
12	30			48 oz.		30 " "
Total	480 cc.	2000 cc.		1440 cc.		1580

Grand Total Intake 2,480 cc.
3,420

Total Output 3,020 cc.
If pyrectic add 400 cc.
If very pyrectic add

Daily Fluid Balance 940 cc.

Date 12 Jan. 1953

Grand Total Output 3,420 cc.

1 A.M.	30 cc.					20 cc. green
2	30	1L. N/S				25 " light green
3	30	↓				15 " "
4	30					18 " "
5	30			12 oz.		5 " clear
6	30					0
7	30					30 " "
8	30					17 " "
9	30					3 " "
10	60					2 " "
11	60		500 cc. blood			5 " "
12	60		↓	15 oz.		20 " green
1 P.M.	60	1L. 5% dextrose in water				4 " clear
2	60	↓				0
3	60					0
4	60					10 " clear
5	60					16 " "
6	60					20 " "
7	60			18 oz.		7 " "
8	60					10 " "
9	60					6 " "
10	60					5 " "
11	60					0
12	60			6 oz.		0
				51 oz.		
Total	1170 cc.	2000 cc.	500 cc.	1530 cc.		238 cc.

Grand Total Intake 3,670 cc.
2,168

Total Output 1,768 cc.
If pyrectic add 400 cc.
If very pyrectic add

Daily Fluid Balance 1,502 cc.

Grand Total Output 2,168 cc.

offensive, the condition is progressing adversely and may precipitate operation in a patient under conservative treatment.

The method of denoting parenteral transfusions by means of an arrow is recommended as it is taken in at a glance. The time taken by any given bottle to go through is seen at once. When the administration of any given volume of fluid is completed the vertical line denoting it is terminated by means of an arrowhead. Where a transfusion of one particular bottle is continued after midnight, that is, is carried over to the following day, it is accounted for only on next day's chart unless the exact amount given up to midnight is entered alongside the vertical line which is then marked off with the arrowhead. It is advantageous to denote all blood transfusions in red so that the same column can be conveniently used for the administration of plasma and other intravenous fluids which are then marked in black or by a previously arranged code of colors.

Under the heading of miscellaneous output are charted such fluid losses as those due to diarrhea and fistulous secretions, the nature of which must be clearly entered as well as its volume. All charts must be balanced once a day, allowance being made for the imperceptible loss of fluid and operations as described. A deficient balance should be represented in red so that it is forcibly brought to mind.

Regarding the routes available for the replacement of body fluids, these can be considered under three headings:

Oral
Rectal
Parenteral { intravenous / interstitial

The oral route is the most important and efficient channel by which fluid loss can be made up. It is simple, physiological and free from complications. Unfortunately it is not always available, particularly when most needed, as in the case of vomiting and following operations on the gastrointestinal tract. It is also the disadvantage that the effects are made manifest relatively slowly, so that this method is of little value in the case of emergencies. The administration of fluids "per rectum," or proctoclysis, has only limited uses, for absorption is apt to be incomplete, the fluid may not be retained, and it is relatively slow in its effects. This route is little used nowadays although its judicious employment in some cases might save unnecessary parenteral transfusions.

By the term parenteral transfusion is meant transfusion by other means, outside the bowel. The intravenous route is very rapid in its effects and commends itself in the case of emergencies. It is the only portal of entry available for the administration of blood, plasma, and amino acids. It has the disadvantage that overdosage may lead to the unnecessary and harmful accumulation of fluid within the body. If excretion is then delayed, as is often the case with saline solutions, pulmonary congestion may result that may give rise to hypostatic pneumonia, that in its turn may precipitate death, particularly in the debilitated. Furthermore the maintenance of an intravenous "drip" requires some extra attention which may be an embarrassment where there is a shortage of staff or where numerous simultaneous transfusions are in progress.

With the discovery of hyaluronidase, the "spreading factor" of certain streptococci, and its clinical application to interstitial or subcutaneous transfusions, the whole field of the usefulness of this route has undergone a dramatic change. This procedure, previously uncertain, slow, limited in its scope and not infrequently complicated by local inflammatory changes, has now become an efficient, clean and relatively rapid method of fluid administration which requires little supervision. It has the further advantage that congestion due to overdosage is less likely to lead to any complications. Interstitial transfusions must not, however, be used in the presence of peripheral circulatory failure as the fluid will not be absorbed and will pool locally. Neither must it be used when the replacement of fluid is urgent or where blood or plasma are required. In the vast majority of our patients undergoing a major surgical procedure requiring parenteral trans-

fusions, the interstitial route is used almost exclusively, excepting of course transfusions during the operation itself. The method has, indeed, proved itself efficient and extremely convenient to the patient, the nursing staff, and the doctors.

Finally the nature of the fluids to be given must be considered, although only very briefly, as the subject is a very wide one and not free from much controversy. The ideal to be aimed at is the exact restoration of the fluid lost by the body, be it blood, water or any given electrolyte. Anything over and above this is superfluous and even harmful. The just appraisal of such needs is, however, difficult and even in the best of practices only an adequate approximation can be made, the quantity and quality of the fluid administered being in the nature of an intelligent guess which is based on carefully prepared intake-output charts, biochemical assays, and clinical experience.

The electrolytes most frequently used are saline, dextrose and glucose solutions of varying strength, potassium chloride and sodium lactate. A word of caution must be inserted here in connection with the use of these substances, particularly when given intravenously. Sodium chloride has an ill-understood property of holding water within the body, and as in disease the excretion of this salt by the kidneys may be impaired, edema and pulmonary congestion may be readily caused. It is thus not infrequent to use saline solutions of less than normal strength (hypotonic solutions) or to alternate them with one or more equal volumes of glucose or dextrose solutions in water. Potassium chloride if given in excess may cause heart block, while the administration of dextrose should not exceed 500 cc. per hour or marked glycosuria may follow. Above all, fluid should not be given parenterally if the kidneys are not excreting urine (for reasons other than deficient circulatory volume) or the tissues may truly become waterlogged.

Industrial Education in Cancer Control

PLANS TO BRING a vitally important message to industrial, office, and store employees are being drawn up by the Canadian Cancer Society. The message is essentially this: Advances in diagnosis and treatment of cancer now mean that a *majority* of the types of cancer that will make up the 25,000 new cases of the disease that will occur in Canada this year can be effectively treated if diagnosis is made and treatment begun before the disease has spread beyond its site of origin.

The Society has appointed a National Industrial Education Committee, under the chairmanship of Mr. Carl B. French of Toronto, to coordinate and assist the provincial divisions of the Society in this work. In a recent report to the Society, Mr. French quoted the Society's president, Mr. F. G. Butterfield of Regina, on the need for an industrial education program: "There seems to be no doubt about the need for taking our educational program to employed groups during the hours of their employment. Since they work in office, factory or store all day, their off-duty hours are spent in relaxation and few come in contact with our normal educational channels."

Mr. French's report added: "Another factor in favor of an organized industrial program is that the Canadian Cancer Society receives donations from some Employee Welfare Funds during our annual campaign (the Society's campaign is in April which is also Cancer Control Month in Canada). This support commits us to direct our cancer education and services towards employed groups."

It was stated that where industrial educational work in the field of cancer was already being undertaken in Canada via pamphlets, films, talks and other means, the reception from both management and employees has been most enthusiastic.

For the first time at Banff—C.N.A. Biennial Convention, June, 1954.

Behind the Curriculum

NORENA MACKENZIE

SCHOOLS OF NURSING and provincial associations are concerned with the revision of basic curricula and the method of their application. It is a perennial problem and a continuing process. The external circumstances of life, however, alter the similarity from generation to generation.

The perplexities and uncertainties of our age are enormous. We are bewildered by the rapid development of new ideas resulting in industrial and commercial expansion; in the alteration of the social, economic, and political structure, and in the speed of communication. We appreciate that all manner of new occupations and techniques have arisen and that there is considerable concern with their implication on education. We are afraid that the fascination of techniques will hold our attention unduly and considerably obscure the fact that life is more than technology and man more than a technician. But this much is clear: the rapid development of industry and commerce in the western world, and their need of development in other parts, have illuminated the reciprocity that exists between a "standard of living" and the health of the people to achieve it. The state of the world is such that one of the essentials of sound political and business principles is that health is not the prerogative of a few but the crown-right of everyone.

The preparation of a program for the achievement of health can be envisaged only in the responsibility of many groups. Organized nursing is one of those groups. The variety of services for which nurses are required is multiplying and almost every country is asking for greater numbers. To try to educate nurses to be sensitive to the opportunities and to the limitations of the socio-economic framework of a community or a country and to understand their relationships with other groups is one of our problems.

Miss Mackenzie is educational director of The Montreal General Hospital School for Nurses.

CHANGES NECESSARY

The manifestations of the necessity for change in the preparation of nurses are legion. In the contemporary scene, a multitude of surveys, experiments, and analyses of our responsibilities and relationships in the promotion of health have taken place and are continuing to take place. The analyses reflect that there is a need for the better preparation of nurses to meet their responsibilities in the total health program. They state that, by way of revision, expansion, extension and rearrangement of the content of the syllabus is required. Different methods of teaching are recommended. They urge that the translation of theory into practice observe the element of time and that the entire program be controlled by the school of nursing. Implicit in the recommendations is the doctrine that responsible practitioners of nursing are those who have a vision of and faith in the purpose of life. The corollary of that is that those preparing and executing an educational scheme, designed for the preparation for service, must possess that vision and faith or the scheme is merely a technical device.

Criticisms relating to immediate personal experience are numerous and they must be taken into account. They, too, are estimations of the causes of dissatisfaction and in turn measure their critics. The authors of the depreciations, if wisely guided, can provide strong reinforcements to the process of curriculum-change and of its administration.

MEASURE OF AN IDEAL

Those charged with the responsibility of educating nurses know that there are great difficulties in realizing

a measure of the ideal to which they aim. When that measure is not realized there is a tendency to place the blame on all manner of circumstances. We hear that lack of control of the student's time, poor administrative and personnel policies, defects of organization and lack of understanding of those in authority are the reasons for the omission of certain courses of instruction, for the lack of integrated instruction, for poor correlation of theory and practice, and so on.

Such deficiencies do exist. Their existence is a formidable obstruction to any program. They are not, however, the only blockade. Good organizational devices and administrative policies will facilitate a plan but the soundest pedagogical principles and the best planned program of instruction will only attain a measure of success when they are the *tools* of those who know how to use them. That is, when they are employed by those who, prepared for their particular responsibility, have a conviction of the purpose of life and how education serves that purpose.

That is not, in any sense, to minimize the gravity of the obstacles with which some teachers and students contend. Rather, it is to show the interdependence between an opportunity for teaching that has been created with a completeness of regard for its purpose and the ability of the teacher to exploit the occasion.

There is further evidence that ought to awaken the unawakened—if they exist—among us. Too many nurses are moving continuously from one post and place to another apparently using their technical equipment as a means of pursuing their own happiness and escaping responsibility. Many, no matter where they are, will not accept their fair share of the "awkward hours" because they conflict with their personal life. Serious young women accept positions for which they are—or are not—qualified by preparation and temperament. It is common knowledge that, qualified or not, they become frustrated and unhappy under the burden of problems which seem to be beyond their powers of resolution.

In other words there are too many nurses who appear to show no conviction of purpose, own no allegiance to anything greater than themselves, or they are not sufficiently analytical to appreciate the basis of their limitations and do something about it or they weary of the apparent permanency of the impediments. For the individual the condition is tragic; as a communicable disease it is devastating.

The judgments of controlled studies and the estimates of the discontented, which even the least observant ought to discover, challenge the mind and spirit of organized nursing. We must accept the evidence that our efforts in helping some young women to become, in the practice of nursing and within their external circumstances of life, "liberated and integrated" personalities appear to be wanting. Also our attempts to improve some of the circumstances required for satisfaction in service have been inadequate.

Confusion and Resistance

Sporadic efforts are being made to fulfil some of the recommendations of the studies but, as the foregoing remarks were meant to suggest, the general notion concerning revision—or, perhaps, reformation—of the preparation of nurses is confusion and resistance to change. It is understandable that this is so because it is difficult to maintain perspective—even when conscientiously trying—when the bombardment for reform is intense and relentless and the day's job so exacting.

Nevertheless, while recognizing the complexity of our age the confusion in our own ranks appears, *superficially*, to be due to two reasons. The assessment of the arguments by those in favor of specific changes and by those who are reluctant to accept them proclaims a wide gap in the standard of judgment. The difference in the standards of judgment is due to the variety of levels of personal and professional development. Secondly, the urgency for reform suggests a pace that is either incomprehensible or that, for one reason or another, cannot be met. (That is not to suggest that all

recommendations in favor of change are right and all in opposition to them are wrong.) *Actually,* it is the disparity in the beliefs of the purpose of education which is the difficulty. Many are unconscious of the basis of disagreement and often it remains hidden even in the face of abundant evidence such as noted above.

In such circumstances the disparity is something to be reckoned with. It is a common failing of many who accept or oppose change to do so in a revolutionary spirit or with too little conviction — that is, without serious thought. The finest ideals and the soundest ideas embodied in the various analyses can miscarry if they fall into the hands of the incompetent—the zealots, the lukewarm, or the unprepared. Joined to that event is the danger that the best of our heritage may be lost in the housecleaning.

Appraising Ourselves

The evidence that we must try to narrow the gap in the understanding of our problem—an inescapable responsibility which we undertook from choice when we became nurses—is that there is a universal demand for a great variety of nursing service within existing health programs and for their institution; a high degree of dissatisfaction in the preparation of nurses; evidence of irresponsibility on the part of some; and intense interest in our professional direction and development on the one hand and bewilderment and indifference on the other.

We have permanent problems. The values which determine the development of curricula for schools of nursing have occupied the earnest attention of some in each generation. We are heirs to the assets and liabilities of that consequence. Again, we must meet the challenge—what is the chief end of our efforts and where must the vital change occur? From the consideration of that decision most of us are asking to be delivered because either we are afraid to appear "intolerant" or to expose our poverty of belief.

No one will deny that, in practice, values have changed. The increasing emphasis of science and, in some instances, the liberal interpretation of religious beliefs have been blamed for the change. No matter where we project the blame, it is evident that the standards which determine moral obligation have journeyed from rigidity to flexibility and sometimes indifference. All the while we have professed, in principle at least, the values of "attitudes, knowledge and skills." But, in educational practice and in service we seem to have fallen short especially of the leaven—it is attitudes and their sequelae which have received the greatest disparagement.

We cannot escape self-appraisal. We must possess some delineation of our vision and faith in the purpose of the medium through which we have elected to serve. The purpose of self-measurement is not only to direct our attention to the obstacles that beset us but to find the source of renewal and take fresh courage in the knowledge that if the challenge of the day is great the resources to meet it have never been greater.

This primary effort directed toward revising the curriculum, is the responsibility of everyone—the "expert" and the "infinite variety" who constitute organized nursing. Certainly, nursing education is the particular business of the specialist. The specialist's gaze is intense. She views her problem in high relief and her solution is supported by what appears to be incontestable evidence. But the execution of the solution lies both in the hands of some who are specialists and many who, while they cannot claim to be specialists, are giving a reasonably good account of themselves within a framework fraught with difficulties. The cooperative and the coordinated effort of both are necessary and they must have a common purpose.

Purpose of Education

Even in this day and age, with so many systems of opinion contending for our loyalty, there are few among us who will object to the belief that the purpose of education is the balanced development of mind and character. It is no less the purpose of nursing education. If we admit to that belief we

must admit to the inherent responsibilities it holds for us.

To be an instrument for the enlargement of a student's "attitudes, knowledge and skills" imposes a partnership in which we are the senior and more responsible partner. Does our thought and behavior reveal an attitude which delights in exploring the relationship of new ideas and their realization in the privilege of service? Is the skill of hand, at once, the outcome and stimulus of the skill of thinking? Do we reveal the guidance and discipline of a "Vision of Greatness"? Does our relationship with the student acknowledge that her development is a personal event—that she does her own growing, at her own pace, and in a manner peculiar to herself?

Furthermore, while our concern lies in a special field, balance implies that our specialty stretches forth into and beyond our immediate environment—that is, the community in which we live and the world which is becoming smaller and, therefore, bigger for the individual. That is to suggest that our foreground—nursing—is stimulated and dependent upon the vast territory of its background. We live and work with others of whose pursuits and need and help we must be aware if anything approaching "integrity" on our part and "integration" of an educational program will be achieved.

Power of Example

The persuasive power of example is the strongest instrument we possess. That example should provide an atmosphere in which a student observes the design of *personal* endeavor reflected in concern for one's fellowmen: *common* endeavor pursued in a spirit of fellowship, and satisfaction and growth correlatives of both pursuits. Unless that be the centre of gravity, provision for additional and integrated subject-matter, concomitant teaching and practice at each level of experience will, perhaps, accelerate learning and be conducive to intellectual pleasure. Their function, however, is still means — and we are still wanting.

Before a curriculum can be revised, therefore, several circumstances must be recognized and believed. We must look within and acknowledge what we believe the purpose of nursing education to be. We must know something of the world in which we live, realize its opportunities for service, the resources which exist to help us meet them and the difficulties attending both. We must know the young women who seek fulfilment through nursing. Those whose duty it is to carry out the letter and the spirit of a curriculum must be qualified as persons and nurses to do so. If we agree to those terms we acknowledge that change is necessary.

Relationship and Responsibility

Many groups and individuals are accountable, therefore, for the serious trust of preparing a program for the preparation of nurses and for its application. It is not the purpose of this article to review the responsibilities of such an assembly. Rather, it is our purpose, as a practising teacher, to recall our manifest responsibility to students by reviewing a primary essential underlying the curriculum—the relationship and responsibility that exist between those for whom a curriculum is designed and those whose tool it is.

When a teacher observes a group of students she sees before her young women of 18 years or more whose educational attainment and other qualifications have satisfied whatever measurements were employed to warrant their admission to a school of nursing. Despite the excellence of the tests, the capability of those engaged in testing, and the success of the candidates they have not revealed all that a teacher will need to know about them. It is also a teacher's privilege and duty to seek to know and to understand each student. It is a personal relationship.

The young women for whom we are to provide an opportunity for growth represent a cross section of the socio-economic structure of Canada and other countries. They have been "growing" in a variety of environments for 18 years. They enter the school with well established patterns of

thought and behavior reactions.

Some have come from homes which have provided a real educational background by virtue of their cultural inheritance or, as often happens, by the privilege provided by a secure family economy and an atmosphere of simple goodness. There are those of like opportunity whose maturity and sense of social responsibility is diminutive because, for one reason or another, they did not utilize their advantages. Others have come handicapped by an atmosphere of "inferior education" due to the limitations of their geographical situation, a low family income, or because of the maladjustment of family life.

The force of such circumstances gradually becomes visible. There are those who have achieved considerable balance in the conduct of their life. There are also the timid and the aggressive—the one preferring to remain unnoticed, the other hoping to be appreciated—both insecure. Again, there are those who are easily frustrated—the highly intelligent because they can assimilate new ideas quickly and readily express them in their performance and the plodder who wearies when the work accumulates too quickly for her pace. The perceptive teacher observes those whose aptitudes indicate the sphere in which they will excel. She also sees those who, desirous of growth and satisfaction, become impatient with restraints and that large number who will "take the blow and cushion the shock" wherever their lines fall.

These young women, differing so widely in native endowment and upbringing, have been admitted to one school. That school must provide the best possible conditions that will help each to attain the stature which her potentialities suggest. The implications are infinite.

The School Environment

The environment into which they come ought to be designed to provide the means for growth which mean change. "To change" imposes a tremendous responsibility but it is the essence of life and, therefore, of an educational environment. The timid must be made to feel secure by a sympathetic "drawing out"; the aggressive must realize that they can obtain their goal in a more acceptable manner. *Some* of slower pace must receive extra help and encouragement. Their scholarship may never be impressive but many have proved in the school, and later in life, that they have capacities and temperamental qualities which a particular milieu requires.

By the same token, the highly intelligent need the opportunity to deepen their understanding at each level of experience—a fact which is frequently forgotten. To assist them to realize satisfaction and growth needs no more apology than the assistance given the slower student. They are, often, the core of the future leaders. Without the security and direction of our help their frustration may induce a personal and, therefore, a professional will-o'-the wisp existence.

There is no teacher, worthy of the name, who has not felt her inadequacy at the impact of such a task. In its discharge the sensitive teacher is dismayed by youth's indifference and resistance to change. She is also encouraged by evidence of the gradual acceptance of change and by the fact that youth is captivated by sincerity of purpose and understanding. There is no room for the assembly-line technique in the teacher-student relationship.

The Teachers

But who are the teachers? They are the members of the health team—nurses, physicians, surgeons, nutritionists, social service workers, and many others whose exertions fall within the orbit of a school and the care of a patient. There are also those whose activities in the community are more remote but who are, nevertheless, essential factors in the total health program. Above all, the greatest teacher is the patient—in his home, in the clinic, or in the hospital. We shall concern ourselves with the first and last of these.

No nurse escapes teaching. Whether her first duty be to teach a student to care for a patient or to care for a

patient herself, she is a teacher. Caring for a patient is the most subtle of all teaching. It is humbling to reflect that one's presence, silently but perceptibly, winds in and out of a student's life forever. We need to take stock of ourselves. The continuing presence ought to be a bright one.

What can be asked of a teacher? The least that can be asked is that she knows her subject and that she presents it convincingly—that is, she must be a first-class technician. However, to discharge her privilege she must be more than a technician. She must also be a woman of wide sympathy and understanding, conscientiously striving to increase her knowledge, judgment, and wisdom. The rigorous discipline of study—leading out from and beyond her particular field—and the application of her growth in her specialty must be her first preoccupation. How can she keep the trinity of ends—"knowledge, skills and attitudes"—in view in her teaching unless she, herself, be an exponent of those ends? Her skill ought to display her knowledge and reflection and her thinking envisage application. She must know her student's needs and exhibit in her teaching—wherever that opportunity occurs—the unity in the "subject matter" of the curriculum. Unless that be the meaning of "integration" the student, instead of being awakened by the revelation of completeness, becomes the recipient of a teacher's storehouse of dead facts and the principle of integration reaches its destination on paper. The impetus for that vision and growth comes from within. It should, however, be excited and supported by the needs of those whom the teacher serves.

It is in the care of a patient, no matter where he is and no matter what his lack of well-being, that the meaning and purpose of teaching and learning come alive. The mutual privilege between patient and nurse radiates learning incarnate. Each learns from and teaches the other. A student, who has participated in the care of a patient directed by a nurse who is sensitive to and stimulated by the problems of his immediate care and awakened by the social, economic, and other implications of his illness, has experienced the most important event in her development as a person and as a nurse. The student's attention has been directed to the cause of the patient's misfortune and to her responsibility as a nurse and as a citizen. She has also witnessed the relationship of her own profession to others in a total health program designed for bettering the conditions of life.

That teacher has demonstrated that patient-care extends beyond the bedside. The student is directed to ask: "What caused the patient's condition? What circumstances in the community contributed to it? How could it have been prevented? What are the far-reaching effects upon the patient, his family, and the community? How and by whom will health—or a measure of it—be restored and maintained?" Such awakening compels teacher and student to seek the answers. That does not mean that either will be responsible for the entire care of the patient; it does mean that to be a responsible practitioner of nursing each must know to what end she is working—what is to be done for the patient, why and by whom. That is how a student learns to use the resources of the socio-economic structure of the community in the care of a patient. That is how the tragedy of inadequate resources awakens her to her full responsibility of citizenship and that is how the importance of the more remote teachers is revealed.

The most urgent need of the moment is more teachers of that calibre—teachers whose standards of thought and character disclose diligence in the continuous preparation for better service that unveils inner resources and patterns of behavior worthy of emulation.

Constructing the Curriculum

We must examine the problem of curriculum change and of its administration with new eyes—that is, not only from the circumscribed view of the inadequacy of "courses of study" but in the panorama which reveals why

we are not meeting the challenge of a complex world more effectively. We shall need all the existing aids that we can command to help us attempt not what can be done but what ought to be done, bearing in mind that balance must be maintained between "change" and "tradition." The assistance of the members of the health-team—the specialists and those who are not specialists—the counsel of those who have had experience in the use of the scientific principles underlying curriculum construction and the help of many others will be necessary. The real value of their assistance depends upon a primary conviction—what they believe the purpose of education to be. It is that conviction that will supply the pre-eminent guidance of values and purpose. It compels personal assessment and study. The vital change must occur in ourselves.

Surely we can try to so ordain our efforts that our young women, inspired by our example, may venture forth well supplied with the technical knowledge and skills peculiar to nursing, possessed of the understanding that there are no boundaries to the knowledge and skills that they will need in the future.

Happiness Brings Health

HELEN SPEIRS

IT WAS A RAW, cold, foggy day—a real London pea-souper in fact—when I called on Miss Irene Gwynne, the organizer of a factory for old people, in the Metropolitan Borough of Finsbury, London.

Inside it was warm and friendly; light, too, in spite of the fog. Although their average age is 70 years, all the workers save two were at their work benches. This was good for, by comparison, when the messenger from a local factory called to carry away some of the work, he said that half of their workers were not in.

The factory is run on two shifts. Thirty workers come in the morning and another thirty in the afternoon. Each shift works for two hours and each worker is paid at the rate of ten shillings a week. The workers are skilled and unskilled. Some have not worked for many years and, indeed, had resigned themselves to retirement and the deadly prospect of passing the time on a small income.

When the time for retirement comes, life without companionship becomes a wearisome burden and there tends to be no escape from monotony except the contemplation of one's symptoms. The fingers that were once nimble weaken and the brain that was once alert becomes senile. Hospital or a home for the old becomes the only future, with its inevitable loss of freedom and independence.

To combat this prospect Dr. Blyth Brooke, the medical officer of health for Finsbury, planned the factory for the old in his Borough. At first six old folk were gathered in a room in Finsbury Health Centre, where they made coat-hangers under Miss Gwynne's supervision. This was two years ago. Today the factory is installed in a three-storey house. It is fitted with trestle tables, chairs, and sewing machines. These machines are supplied by the factories that require special work.

Busy and happy

Miss Speirs is a state registered nurse residing in London, England.

Being over 70 is a boon

Although old hands do not work as quickly as young, the work is carried on steadily and the result of a week's work is impressive. A medical firm orders the elastic straps for finger stalls. They have provided the machine that stamps the eyelet holes. One old gentleman runs this and the threading is carried out by old ladies. Between them they turn out 25 gross each week. Another washes small bottles for oily drops and the old ladies fit together the parts which make pipettes. They turn out 80 gross each week. As well as working for firms, the factory produces goods of its own. Miss Gwynne designs nightgowns, toys, aprons, and coat-hangers. Of the latter, 4,000 were made last year. A new task that has been allotted to these workers is the testing of pens. They have to write out a certain number of words on paper. By examining this the manufacturers of the pen can detect faults in the ink flow and so forth. This is amusing to watch, for one is reminded of the tedious punishments which one underwent at school writing out lines, the only difference being that one was not paid to do it. Those I watched had beautiful handwriting—neat, legible, not at all stereotyped. They also had to record the temperature of the room on their lines, this being a necessary part of the test.

They also assemble electric iron elements, pack animal wool, and help the local public library with their card indexing.

Work is sought, comes in steadily all the while, as in any other factory. Nor is it given in a sense of charity. It is a business arrangement—the firms pay for work well done. The old folk tell each other about their opportunity and often there is a waiting list of prospective employees. One or two do work at home but the basic idea is to bring them out to meet others, away from their homes or rooms. This gives them the feeling of belonging to the community as well as playing a useful part in life.

The atmosphere is one of busy contentment and a happy relationship exists between Miss Gwynne and the workers. The latter are never rushed to get their work done but sometimes they have to hurry a little if a big order comes in for a delivery next day. The old folk come up to scratch on such occasions and at the appointed time the finished order goes out.

The factory is not entirely self-supporting. The scheme is organized by the Employment Fellowship in con-

nection with the Finsbury Borough Council and is subsidized by a grant from both organizations. An interesting fact about this concern is that it is new and has to feel its way without guidance from other's experience, for it is the onlv factory solely for old people.

The workers run a little canteen in connection with the plant. Tea is served at eleven each morning. A small charge is made per cup. The workers decided that they might make a profit on this enterprise and with it have a bumper party at Christmas time. This is entirely their own affair.

As many of the workers suffer from one or another of the ailments which accompany old age, it is good to visit such a concern, good to see the interesting and varied work that they do and, last but not least, to realize that while they occupy a workbench in their factory there is less chance of them having to occupy a bed in a hospital ward.

I desire to thank Dr. Blyth Brooke for his help in preparing this article.

Memorial Plaques Unveiled

ON FRIDAY AFTERNOON, January 23, two plaques listing the names of the graduate nurses of the Royal Victoria Hospital, Montreal, who served overseas in the First and Second World Wars were unveiled by His Excellency, the Governor General, the Right Honorable Vincent Massey. The Rt. Rev. John Dixon, Anglican Bishop of Montreal, opened and closed the ceremony with prayer.

Following the unveiling, Mrs. Colin Sutherland, president of the Alumnae Association, presented the honor rolls to the hospital. They were accepted by Mr. G.

Photos by Lister, Women's Pavilion, R.V.H.

The Governor General meeting nursing veterans

One plaque is unveiled

Blair Gordon, president of the Board of Governors.

His Excellency then moved along the three lines of nurses while Mrs. C. A. MacIntosh presented each one of them to him. There were 20 First World War and 31 Second World War veterans present.

Among others presented to His Excellency were Mrs. M. A. Stanley, honorary president of the Alumnae; Miss Helene Lamont, director of nursing and vice-president of the Alumnae; Miss Avis Fyshe who had been commissioned by the Alumnae to carry out the inscriptions on the honor rolls.

The Memorial Plaques hang on either side of the gymnasium doors in the main lounge of the nurses' home.

Following the ceremony tea was served in the gymnasium during which members of the Medical Board, their wives, and others were presented to His Excellency.

—JEAN E. MACGREGOR

Back Issues Available

The National Office of the Canadian Nurses' Association has back issues on hand of several professional magazines. They would be pleased to donate them to any institution or organization able to make use of them:

American Journal of Nursing—1949 (Dec. missing); 1950 (Oct. missing); 1951 (complete).

Canadian Hospital—1951 (complete).

Canadian Journal of Public Health—1951 (complete).

Hospital Progress—1951 (complete).

Hospitals—1950 (complete).

Modern Hospital—1951 (complete).

Upon request to the C.N.A. at SUITE 401, 1411 CRESCENT ST., MONTREAL 25, QUE., they will be sent express postpaid. First come, first served!

Doctors who want to hold on to their female patients are advised to pay more attention to the "little things women find so important," according to a survey taken among women of various ages by *Medical Economics*.

Each woman agreed that her doctor was a pretty fine fellow but most listed a series of irksome items that should be checked by doctors:

"She wants to be greeted by a friendly, understanding receptionist and nurse, rather than by an irritable one who rasps out an order to sit down and asks her name and ailment as though she were guilty on both counts of a misdemeanor.

"She wants a clean, cheerful waiting-room supplied with current reading matter, instead of with old, battered magazines that look as if somebody had teethed on them. A patient isn't particularly impressed by a lush office, the latest creation of a big-time interior decorator, because she is apt to wonder how much she will have to chip in to pay for it.

"Most important is a conference with the doctor before the examination to tell her what's ahead and put her at ease for coming trials. What happens too often is that the doctor suddenly descends on her with poundings and pushings and interrogative monosyllables. If she has had no previous meetings with the gentleman, she feels most uncomfortable about this abrupt, personal introduction.

"She wants a dressing room with a chair, clothes hangers and a mirror, plus an illustrated posted diagram telling how to put on the examination gown.

"She wants to be taken seriously, have her questions answered and her worries calmed, and the diagnosis explained in words that can be understood."

Public Health Nursing

The Public Health Nurse in the Home

RUTH FREEMAN, B.S., M.A.

THESE ARE DAYS of choice in all phases of nursing. We are plagued with a shortage of nurses and faced with the fact that future sources of supply are limited. At the same time public awareness of health needs is growing, the numbers of people seeking hospital or home nursing care are increasing rapidly. Those of us who are responsible in some way for the provision of nursing service must look askance at every present activity. We must ask, "What difference will it make to the family or to the community if this service is provided?" "Just what can the public health nurse do in the home?" "Could equivalent service be provided by another means at less cost to the public?" "Does increasing dependence upon hospital care for acute illness reduce the importance of home care of the sick by qualified nurses?" Voluntary agencies, charged with the wise spending of money donated by the public for the alleviation of suffering, must be particularly rigorous in their appraisal of service outcomes and in the direction of program.

The public health nurse in the home has three basic functions—the provision of expert nursing care, including the supervision of nursing care given by others; provision of family health guidance; and coordination of the efforts of the family, agency, and community for health care. She is practitioner, teacher, interpreter, facilitator, stimulator, listener, organizer. She is the generalist on the health team, taking the knowledges of many related fields and selecting, synthesizing, adapting, interpreting this knowledge, welding it into a new form so people can put scientific information to work for improvement of their way of life.

The traditional responsibility of the nurse for providing expert practitioner services that contribute to the medical management of illness or health supervision has not lessened in degree, although it may have changed in content. The kinds and complexity of treatments to be administered in the home have not diminished. The careful, slow personal care of the patient that was the backbone of pneumonia care a few decades ago has been replaced by such activities as giving a great variety of drugs by deep injection, each with its own characteristic problems of administration, of adverse reaction, of indication and counter-indication that must govern the nurse's observation of the patient so the physician's orders may be modified if necessary. Treatments for orthopedic care, for pre- and post-hospital surgical care are likewise varied and difficult, requiring unusual knowledge and skill. The nurse in the home is also participating in a broader way in diagnostic testing and in the collection and handling of specimens—another area requiring technical expertness and good judgment.

New areas of care are also developing. Chronic illness, for example, is placing new demands on the ingenuity and perceptiveness of nurses. We are learning that nursing management of chronic illness is a subtle and complex task, though some of the elements of care may be relatively simple.

Another facet of nursing service in the home is the supervision and training of others who provide nursing care. Family members, practical nurses, neighbors, grandmothers may be giving the greater part of nursing care. Even though the nurse herself does not give

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direct care to the sick, she must take the responsibility for seeing that it is safe and of good quality. This requires teaching skill of a high order, because the home nurse must not only know the required procedure, but must know as well the principles involved in giving care so she can adjust to new or unusual conditions. For example, in teaching an individual to administer insulin to himself, the nurse must do more than demonstrate the method of injection. The patient must understand the nature of the sterilization process, else he may boil equipment carefully then contaminate it by careless handling. He must understand the action of the insulin, the difference between types and the speed of action, the relationship between food intake and insulin need.

In diseases of long duration, the nurse may provide continuing supervision and support to the family. This, too, takes unusual skill—it is much easier to do the job one's self than to help another to give good care with unrelaxed attention to details that are necessary to avoid complications or discomfort.

Although nurses have been concerned with health teaching from the very beginning of the public health movement, this responsibility has been broadened to one of more comprehensive family health guidance. While it is obvious that the nurse is not the only worker providing such counselling, she does stand in a focal place. Because nurses are the most numerous of the professional workers providing health service they are usually well known to families. People are accustomed to look to them for help in illness or health situations and have implicit confidence and trust in their helpfulness and integrity. It is natural for them to look to the nurse to guide them in family health care as they have looked to her in the past for help in illness situations.

The scope of such counselling is enormous. Teaching breast self-examination techniques, interpreting the "no-no" stage in a child's development, explaining the individual nature of arthritic treatment to a family who felt they were being denied treatment with cortisone because they had no money to pay for medical care, teaching a young father to help with the physical care of the new baby are examples taken from one nurse's case load. They could be multiplied indefinitely.

Concepts of family health counselling have broadened and deepened. A few decades ago literature on patient and family advisement was liberally sprinkled with references to "persuasive approach," "forceful teaching," and "securing cooperation"—the latter referring to getting the family to cooperate in the plans made by the nurse or the agency. There were many charts or schedules of teaching content to "guide" the nurse in teaching families in particular teaching situations. The object was to get the family to accept and understand the facts, attitudes, plans or methods that were formulated and presented by the professional worker. Interviews were "controlled," teaching was "guided," families were "motivated" in the direction of the desired action. When teaching was provided in groups, elaborate lesson plans saw to it that the course of the discussion did not waver. True, occasionally by slyly worded questions we tried to get individuals or families to "discover" what it was we wanted to say, and labeled it democratic discussion, but in general the course was clear. Attention was in general centred on physical conditions and care, with some "rules" for mental hygiene interspersed.

Since that time several things have happened to change these concepts of counselling in health. First, the addition of the word "social" to the definition of health added a new dimension to health care. This placed ability to relate one's self to others in the family, community or the world on a par with maintenance of physical health and the development of emotional maturity and stability as a criterion of health. It demanded competence in recognizing attitudes and group behavior that was inimical to health or destructive to the personality of the individual, as well as attitudes and behavior that interfered with the

conduct of the health agency's program.

At the same time the rather restricted, timid approach to promotion of emotional health was replaced by a quickened, aggressive interest. Psychosomatic medicine became a fashionable field for discussion. Psychiatrists turned their attention to a contemplation of the forces and patterns of relationships between people as they affect emotional health. Interpersonal relations—the influences and significance of the need of people to associate themselves with one another and to gain satisfaction of their own needs through such association—became a major area of investigation. Anthropologists, physicians, biologists, psychologists, educators, and other professional groups began to compare and synthesize some of their findings about the human personality and the forces that mold it. Health counsellors looked anew at the ways in which personality development affected acceptance or rejection of health care, and the ways in which the provision of health care was in its turn affecting personality or an individual's concept of himself. Social and cultural patterns were no longer seen as something to which teaching must be "adjusted"—they were powerful forces deeply affecting individuals that might be turned to the support of health care or, in some cases, that served as a formidable, entrenched adversary to be routed only by persistent canny guidance which could change attitudes sufficiently to permit good health care and the security of group conformity to exist in amity.

We have also learned that a family's health competence must be measured by the degree to which they are able to think clearly and constructively about health problems of themselves and of their society. The family must decide for itself whether or not to seek preventive medical care and be able to plan for the type of care that is suited to its needs and to the facilities available. They must increasingly be able to decide whether they want to pay for medical services of a basic nature through their own individual efforts or through application of large group insurance methods. They must decide whether the advantages of a good breakfast outweigh those of that extra 15 minutes in bed.

The spotlight in health counselling is no longer on the professional worker but on the individual or family. They are the star performers—the key people in getting the job of health maintenance done. Counselling is directed not at doing things *for* people but toward building the capacity of the family to do for itself. Adequate health care requires that the individual or family recognize their own place in care; use their natural anxieties, tensions, and fears that occur during illness in a constructive way; accept and live successfully with incapacity that cannot be reduced; use illness or disability as a positive rather than a destructive force, as a stimulus to greater knowledge, maturity and personal power. Workers have learned to be concerned about what the individual wants and feels as well as about what he knows. Health maintenance is recognized as primarily the responsibility of the individual or family, with professional workers standing by to build family competence, increase understanding, and reduce the physical and emotional costs of illness or disability.

The public health nurse is not only a teacher or adviser—she is an expert resource who uses her own personal attributes as well as her professional knowledge and skill to increase family competence in health care. She strives to reconcile and synthesize what she sees as family needs and desirable behavior with the purposes and needs of the family as they see them, and to direct family thinking and information, seeking so they can jointly come up with an acceptable, workable answer that is safe and effective. She recognizes that just as the attitudes and beliefs of those she serves grow out of their cultural backgrounds and experiences, her own values and feelings have a cultural, experiential base.

Finally we have learned that health counselling cannot be a series of isolated, disconnected experiences. People learn within the context of all of the influences and forces that surround them and to which they give their at-

tention. The child who is told to wash his hands before meals and who finds no handwashing facilities in the school is being counselled by both experiences. The family which has had an unfortunate experience with nursing service and then receives an appeal for funds for a necessary humanitarian work—visiting nursing—is equally confused by the differences it has encountered. Furthermore it will be difficult for them to accept and use future nursing services until the force of the previous experience is counteracted by a new and good one. Counselling goes on in a continuum. The individual's whole experience with health services becomes an integral part of the counselling process.

The public health nurse also interprets to the family the facilities and attitudes of the community. She promotes understanding of its agencies, both public and private. She helps people to use those agencies wisely—not expecting more than they are prepared to give, not failing to use those that are available. She refers the individual to the right place at the right time, telling him what to expect, what information on materials he should bring with him, and helps him decide what questions he might need to have answered.

Even more important, she brings to each person she serves the assurance that his community is concerned with his welfare, concerned with him as a person. In many instances she kindles an interest in possible reciprocal action, so the person served by his community also sees ways in which he may contribute and so gain the sense of "evening up the score." For example, the person treated for venereal disease may contribute to his community program by interpreting to others who may be infected why they should come for treatment, by helping to receive new patients in a clinic, giving them the reassurance of talking to someone who has their own problem and has taken steps to meet it constructively.

This then, we expect of the public health nurse in the home—expert nursing care of the sick; teaching and counselling that provides the family with the information and guidance they need to meet their own health problems constructively; supervision of individuals with less experience who are giving nursing care to others; providing information and facilitating mutual helpfulness between community agencies and facilities and the people who need their services.

The next question we must ask is, "Are we using this potential for nursing care in the home to the highest possible degree for the promotion of human welfare?" Here I am going to propose a series of questions, rather than suggesting answers.

First, are we using potential nursing power to the fullest in planning for institutional care of the sick? We hear constantly of ways in which the hospital is trying to emulate the home. Evidence of this is seen in development of smaller units of care, greater participation of the husband in delivery care, using volunteers among mothers of patients to participate in child care, and "substitute fathers" for those who have none of their own, placing mother and baby together following delivery, and many other adaptations.

It is possible that with a new look at community facilities as a whole some of the jobs now done in the hospital might be done just as well, and much more economically, at home. Early hospital discharge of maternity cases has become quite commonplace. With careful preparation of the home and family and continuing supervision by the public health nurse, such care seems reasonably satisfactory to the patient and much less expensive to the community. New home care programs are being developed in many communities, especially for long-term illness, with medical care provided by the hospital, clinic or private physician. Such programs can sharply reduce the need for hospital beds, already far below the standards we feel would be desirable for optimum care.

What can we learn from the extensive home delivery services offered in Great Britain and in the Scandinavian countries? While it is not entirely clear that the services so provided are equivalent to those that could be se-

cured in a first-class hospital, definite advantages and economics would warrant a careful look. A review might reveal many phases of care of the sick, now carried in hospitals, that could safely and economically be transferred to the home. Obviously the answer requires consideration of workers other than nurses in the home—such as housekeeping aides—but nursing service would provide the key since it would, in many instances, be the continuing supervisory and liaison force between hospital and home.

In this connection a subsidiary question needs to be raised—Are public health nurses, or representatives of public health nursing services, serving on appropriate planning bodies that are concerned with over-all policies and programs for care of the sick and maintenance of public health? Sometimes there is a tendency to have decisions about medical care made by an all-medical group, or to place planning responsibilities only upon the official agency and, in particular, upon the medical officer. Such selection of membership for planning groups is no longer suitable, since social, economic, educational, and nursing factors may have as much weight in care as does the actual medical supervision.

Hospital plans may be made without reference to agencies concerned with home care. Then, after plans have been made, nursing and other agencies are called in to give assistance in implementation. This is, of course, better than no conferences at all but calling for such help before rather than after crystallization of over-all plans might result in quite a different pattern for total care.

Another subsidiary question relates to the degree to which nursing is included in medical care plans of an insurance nature and the type of nursing so provided.

Another big question I would pose is, "Are we taking full advantage of new opportunities for service?" As the amount of acute illness cared for at home diminishes, there are compensatory demands for care of the chronically ill and convalescent, for pre- and post-hospital care and for supervision of the well child and adult. In these fields there are many medical and technical advances that might well change patterns of service. The field of rehabilitation opens up great vistas. While special centres and facilities in institutions may be needed for initiating treatment, in many instances the long, hard pull comes in the supportive program in home and family.

Industrial health care, still inadequate in many small plants, can frequently be expanded to the benefit of the worker and his family by part-time services provided by community nursing agencies. Care given by full-time industrial nurses may be enriched and supplemented by community services given by the local nursing care association. For example, the industrial worker who has a low threshold of fatigue may need guidance in relation to diet, recreation, and home activities. The nurse in industry and the nurse in the home can work jointly with the problem, planning together for the best results. Thus the wife as well as the husband is counselled in relation to the necessary adjustments, his needs are seen in relation to the total family, and the result will probably be much more far-reaching in its effects. Generally such combined service is more satisfactory than having the industrial nurse carry home visiting service, since the community nurse has a broader range of responsibility and can integrate necessary special teaching with over-all family health supervision.

While it cannot be classed as a *new* opportunity, it is important to determine whether counselling and guidance opportunities are fully recognized and dealt with. Is sufficient time allowed for such activity? Are nurses as concerned with safeguarding the personality development of the small child —of assuring him of love and an opportunity to grow in independence and without the handicap of fears, anxieties, and unnecessary restriction—just as much as they are concerned with teaching the mother how to give the daily bath or to watch for signs of illness? Are we as concerned with how a daughter *feels* about giving care to

a bedridden mother who has been helpless for months, as well as with how well she can carry out the necessary nursing skills?

Subsidiary to this is consideration of whether nurses are using the *methods* of providing service that are most effective. We know, for example, that in some instances "giving advice" may be much less productive of changed behavior than counselling in such a manner that the family or individual takes the lead in deciding what to talk about and in which he is encouraged to talk freely and to make his own decisions. We know that if reassurance is given at the wrong point, it may make an individual feel he would be a sissy to admit that he was frightened of an operation or afraid of the social adjustments he will have to make if he goes to a tuberculosis hospital. A better method might be encouraging such expressions of fear.

Of course it is important that the nurse provide accurate, comprehensive information, and that she show people how to carry out procedures in which she is expert. In these areas, too, method may play an important part. Our war experience has taught us that it is possible to teach skills very effectively in a short time by the use of training procedures based on controlled content and a standardized method. The Red Cross is using a modification of this technique in teaching home nursing. For some parts of the nursing job, some adaptation of this technique might be very useful.

Most recently, much has been learned about the way individuals learn in groups as contrasted to the way in which they learn individually. People in groups, learning from one another and being stimulated to further learning by their association with others who have similar problems, seem to build a sort of atomic pile of ideas and activities that produce more acceptable, more numerous, and more valid answers *on their own* than do those who learn as individuals. For maximum effectiveness, however, good group leadership is important. The situations under which learning takes place and the factual information made available to the members must be adequate and of high quality. Should we be trying out the possibility of substituting group work for some of the counselling or teaching now done in a one-to-one relationship with nurse and family?

All of the above questions can be answered in the affirmative only if the public health nursing services available are of the highest possible quality. Poor home care cannot substitute for good hospital care. Impractical or poor quality industrial nursing service will not be saleable. A poorly organized and directed group may succeed merely in pooling ignorance and in perpetuating misinformation. So it must be assumed that the fullest use of nursing potentials is based upon a well prepared staff, high job satisfaction, with an on-going in-service educational program that keeps them up to date, alert and highly interested in the work they are doing. In assuring this the leadership and support of non-nursing groups is most significant.

The public health nurse in the home is, in the minds of those she serves, one who brings comfort and a feeling of security and confidence at times when help is needed. To the public she is an economical channel for building into the lives of people the things scientists and physicians have learned about health in such a way that they can lead fuller, happier, more efficient lives because of these discoveries. To those responsible for the administration of health or nursing services she is a precious commodity, to be used carefully and wisely so every possible good can come from her services with satisfaction to herself and to those she serves. It is a job for all of us—the public, health officials, board members, physicians, and nurses—to make the public health nurse in the home the potent, happy, helping person she is capable of being.

While the major cause of hypertension is not known, the simple lowering of blood pressure is conducive to lesser cardiac disability, consequently to a longer and more useful life.

Institutional Nursing

Supplies are Money

OLIVE DENNISON

MY TOPIC is a very broad one. It is more than a topic—it is a fact. Dollars converted into supplies still spell dollars. In your storerooms and throughout the hospital where supplies are kept try to visualize dollars instead of supplies on your shelves. If you do would you make any changes in your purchasing methods or means of control?

Of course none of us is perfect but too often, I fear, we let ourselves get into a buying rut. We would find it an interesting experience to figuratively dissect one of the large volume items that we have been buying routinely for the past year to see if we could improve on what we have been doing. We may let ourselves in for quite a surprise.

The purchasing agent more than any other individual in the hospital has the rare opportunity of learning about all of the supplies and equipment that go into the efficient operation of the hospital. Someone once said, "Your mind is like a parachute. It's no good unless it is open." A questioning mind is one of the requisites of good purchasing. We should attempt to see visiting salesmen without unnecessary delay. A salesman's cumulative waiting time, whether you realize it or not, becomes a part of the company's overhead which then becomes part of the price the hospital pays. Haphazard buying will become a source of annoyance and a headache. Good buying is a constant challenge.

Let us look at a few of the main items purchased by hospitals.

LINENS

The purchase and supply of linens varies greatly in different rural communities. The administrator does not always have too much control over the purchases in this line. Much depends on whether or not there is an active Women's Hospital Aid Society and the manner in which they wish to make their contribution to the hospital. There should, however, be close cooperation between the buying committee of any such organization and the administrator of the hospital. In many communities the committee in charge makes most of its purchases through the local retail merchants at a given discount or it may purchase in bulk through wholesale companies. The women then do all the sewing of sheets, gowns, O.R. drapes, etc.

In other communities the hospital aids prefer to raise sufficient money to purchase all the requirements ready-made from hospital supply companies and also pay to have the hospital mending done. Although a list of requirements may be given to them, there is still a tendency to overbuy on some items, thus loading supply shelves with things that are slow moving. Buying all linen made up is undoubtedly more expensive; it does also have advantages as it gives more uniformity in sizes and quality.

FOOD

One of the operations which is of vital interest in the dietary department is the purchasing of food. The purchase and control of food is important because the dietary department can make or break a hospital through extravagance and wastage. Ninety per cent of the contentment of the patient depends on his food. Also, good food is one of the best preventives of illness and dissatisfaction among the personnel. The control of food supplies is most important. Try to arrange your storage space so that only a daily or weekly supply is requisitioned at one time. Your main storeroom should be kept locked. In this way there is less temptation for employees to use food indiscriminately. Altogether a much closer control in this expensive department is possible.

Miss Dennison is superintendent of the General Hospital in Morden, Man.

Proper purchasing does not mean purchasing for the lowest price, necessarily, but rather obtaining the greatest amount of food for the hospital dollar, taking into consideration first and foremost the quantity and nutritional value. There are many questions which must be considered. What will you buy and from whom? Current prices determine to a large degree what you will buy. You will avoid foods that are expensive and out of season. Storage facilities in each institution determine what quantities you will purchase. With adequate storage you can take advantage of prices.

Who can you buy from? In some rural hospitals it has been the practice to purchase groceries and meats from local merchants in rotation. This is usually an expensive procedure and should be avoided if at all possible. If the merchants are approached in the right manner and it is pointed out to them that the hospital is operated on public funds and that all purchasing should be done as economically as possible they, I am sure, will be most understanding. You are free then to buy directly from a wholesaler or to use any other cheaper method you wish. You may, however, still wish or find it necessary to continue to purchase perishable items locally.

Meat is probably the largest single item of expense in the dietary department. In rural areas fowl can usually be purchased for a nominal price from farmers after the cold weather sets in. I doubt very much that many of the rural hospitals have adequate refrigeration to enable them to buy meat by the carcass. This may be false economy as the menu then lacks variety. There is also the inconvenience of having it cut up properly. The most economical way for the small hospital to operate is to buy meat by the cuts as it is required. Some butchers will make a reduction on a percentage basis for a month's supply of meat, while another may provide locker service for the month that purchases are made from him. This allows for a purchase of perhaps a quarter of beef and half a pig.

Drugs

One of the most important sections in your drug department is the narcotics. The security and recording of narcotics in all hospitals, large or small, is of vital importance and must be carried out diligently. Here I wish to quote in part from a letter on the subject received from Mr. R. C. Hammond, assistant chief, Division of Narcotic Control, Department of National Health and Welfare:

"First of all, I would point out that as hospitals throughout the country operate under varying circumstances depending on size, management, etc., this Department has always endeavored not to attempt to lay down definite regulations in so far as narcotics are concerned. As long as we feel that individual hospitals work out adequate administrative details in connection with this problem, we do not attempt any form of direction. Regulations in some hospitals forbid the handling of narcotic medications by student nurses whereas in other institutions exactly the opposite is the case. Rather than interfere with the complete training which is so essential to the student nurse, we do not have the slightest desire to establish a regulation whereby nurses in training should not be given every reasonable opportunity to complete such training from the standpoint of administration and control of narcotics. However, we do feel that some senior nurse should be in charge of this phase of hospital activity.

"Referring to the physical security of narcotics, our narcotic auditors, when inspecting hospitals, endeavor to impress upon authorities that keys of narcotic cupboards should be retained in the possession of the supervisor. Security measures fail entirely when keys for narcotic cabinets are left in the lock or hang on a nail adjacent to the cabinet. Moreover we feel that such cabinets should be of solid construction, most certainly without glass doors, with locks of a dependable type. Where medication is kept in a locked drawer in the supervisor's desk, we feel that it should be contained in a locked metal box secured to the bottom drawer. Reserve stocks should be kept in a location where they are double locked and accessible only to responsible authorities such as the hospital dispenser, medical supervisor or supervisor of nurses.

"Perhaps a brief word in respect to the records connected with reserve stock control and ward administration may be of assistance to you. There is no great difficulty in maintaining a record both in the ward and in relation to supplies issued and received. It will be obvious to you that such

records properly kept and regularly balanced against physical stock will at all times ensure that no pilferage of narcotic supplies is experienced by your hospital."

A count should be made and recorded twice daily of ward stock—before the night staff go off duty and again before the day staff go off. This makes a double check on daily usage. If there are any discrepancies this is usually where they are picked up.

The hospital pharmacy is an important department in any hospital large or small. Due to the ever-rising cost of medications, a rapidly increasing proportion of the patients' bills are chargeable to drugs. There are a number of reasons why these costs are mounting and we are all aware of them —more accurate diagnosis and treatment; the increasing use of specific medications for specific diseases; the discovery of new and expensive antibiotics; vitamins and hormonal preparations; also the desire of both the doctor and the hospital to reduce the length of the patient's stay in hospital. All of these things contribute to the steady rise in costs. There are a number of controls which can help to keep down these costs. So that the likes and dislikes of the doctors may be taken into consideration, the purchasing of drugs should be the responsibility of one person. He or she can become thoroughly familiar with the new drugs and the supply houses from which they may be purchased. Each hospital has its own particular problems as far as storage is concerned but a few guiding hints may be of some assistance in your purchasing:

Buy in as large quantities as is practicable. The advantages are worthwhile as the price is reduced and freight or express charges are paid. It also gives one enough stock on hand to avoid constantly sending for small orders of single items.

Do not be tempted to overbuy for the size of your hospital—or the number of patients you have per day which is more important—at what you may think is a saving. Remember that working capital may be sitting on your shelves.

Beware of new drugs in large quantities. Until a new drug is well established, particularly in the smaller hospitals, it might be a better policy to have a prescription from the drugstore for the individual patient. Only after such a drug is being used consistently, put it in stock.

Discuss the drugs with the doctors and try to reach an agreement on both stock and expensive drugs such as liver extracts, vitamins, germicides, cough mixtures, sulfa preparations, and antibiotics. This will help to eliminate a multiplicity of preparations all bearing different and confusing trade names.

Try to gauge the buying of unstable compounds or drugs so that there is as little loss as possible.

Equipment and Furnishings

This may not be a very great problem at the present time with so many newly furnished hospitals. However, it should be watched carefully. A few new articles added each year will spread the cost yet keep the equipment up to date and your hospital attractively furnished. Proposed purchases may be discussed with the staff that are going to use them—first, because they may have constructive suggestions to offer, knowing what is required and, second, they will appreciate its value and have a personal interest in its care. When a new piece of equipment is purchased the staff should be instructed in its use and be familiar with its operation.

It is not good economy to buy a cheap grade of equipment. In most cases it will be many years before it is replaced and should be purchased with that in mind. If any large or expensive equipment is to be purchased, it is advisable to contact other hospitals or, better still, go and see the equipment in operation before purchasing. Larger hospitals may have various types from different suppliers and the recommendations or criticisms from those who are using it can be of value to you in your decisions. Here again price should not be the determining factor. Another source of information on hospital equipment, drugs, and surgical supplies is the current hospital magazines. *The Canadian Hospital* has a wealth of information in articles and advertisements on the latest products in all fields and can be of considerable help.

Cleaning and Laundry Supplies

These demand a fairly large expenditure

in any institution. The market is loaded with soaps, detergents, floor cleaners and magic preparations that take all the work out of cleaning. It seems that no one has brought out a substitute for good, old-fashioned elbow grease! Try to discover the most suitable soap or detergent for doing a good job on the type of floor covering or paint you may have and stick to it. Too many changes tend to cause waste as many employees have little regard for the cost or the amount necessary to do an adequate job. In the laundry hardness or softness of the water supply will help to determine what type of soap or detergent is best. Here again, frequent changes and experimentation result in considerable wastage.

I have not touched on contract buying. My own experience has not been too successful in this regard. It may save some time in ordering but, in any event, stock must be watched to ensure a constant supply and also that you are not building up too large a surplus. There does not appear to be any reduction in price in this method, although in some instances you might be protected from a rise in price. The salesmen of many companies seem to prefer this method as it ensures their business for a stated period. However, it does not seem essential for a small hospital.

Control

Once you have an adequate stock, how are you going to control it? Control of all supplies means money for your hospital. It is one of the prime essentials. A day-to-day record is the best method of control. We have set up a system which is approved by the Associated Hospitals and from whom we received considerable assistance in its establishment. To begin with, all invoices are carefully checked with the goods received. The date, supplier, unit price, and amount received is recorded for each item. Supplies are then requested on a requisition form. The amount of each article withdrawn from stock is recorded and the balance on hand shown. If you have purchased from more than one supplier, you may see at a glance which one is giving you the best price. As the daily entries are made and balances shown you know what should go on your "want" list. This saves you endless time and many individual orders to make out, with the resulting invoices to check. It is also a simple matter for inventory purposes to determine the value of stock on hand.

This all may seem like a tremendous task in a busy day. I must admit that I thought it was at first. However, I find that if it is kept up daily it really works out very well. This system requires some cooperation and should be explained to your staff, as it may be a new procedure for them also. With their cooperation, one trip to the dispensary and supply room a day should be all that is necessary. The very fact that the staff knows that all the supplies are being carefully controlled is a deterrent in the amounts that are used. And so, just as purchasing is a challenge, and not just another nuisance, the control of supplies is a greater one and requires daily vigilance.

The announcement in Nursing Profiles regarding the new appointment and recent retirement of Victorian Order of Nurses personnel focuses our attention on the magnificent contribution this national organization has made to the education of nurses since its foundation. Long before there were organized public health nursing courses in our universities, the Order recognized the fact that a nurse going into the home to provide care required more knowledge and somewhat different skills than she had acquired in the course of her basic training. For years the Order maintained its own centres where nurses were taught.

When these centres were abandoned in preference to the university courses, the Victorian Order launched a program of giving scholarships to assist potential staff to secure their more advanced education. Since 1940, over $150,000 has been spent in this worthwhile cause. Fifty scholarships of $750 each are available for the 1953-54 university session. Nurses who are interested should apply speedily to *Miss M. Christine Livingston, Chief Superintendent, Victorian Order of Nurses for Canada, 193 Sparks Street, Ottawa 4, Ontario.*

Aux Infirmières Canadiennes-Françaises

Le Nursing du Prématuré

Z. OPPLIGER

Le Prématuré en Chambre Couveuse

(Suite de l'édition de mars)

La chambre couveuse: Le prématuré de 1,900 à 2,200 gm. est mis en chambre couveuse. A la naissance, il reçoit les mêmes soins que le prématuré allant en isolette. S'il n'a pas dû être réanimé, l'accoucheuse lui fait, après les premiers soins, une toilette à l'huile. Le prématuré destiné à la chambre couveuse est complètement habillé. Des layettes stériles et chauffées sont toujours prêtes. Ces layettes comprennent:

Les pansements, ligatures, et l'ouate pour les soins du nouveau-né; 1 corselet d'ouate; 2 brassières en tissu molletonné; 1 bande ombilicale en tissu cambric; 2 petits bas en tissu molletonné; plusieurs petits langes molletonnés; pour la tête, un petit bonnet en gaze doublé d'ouate; des mouflettes pour protéger les mains.

Cette façon d'habiller le prématuré le protège contre le refroidissement. On le transporte bien couvert à la chambre couveuse, dans un berceau chauffé, pourvu d'un édredon. Il est placé alternativement sur le côté gauche, puis sur le côté droit. Les bouillottes sont changées toutes les trois heures et dès que la température est stabilisée, on les supprime. Leur température ne peut pas dépasser 50° C. et elles doivent toujours être mises dans un sac en molleton.

SOINS GENERAUX

Ils sont les mêmes que pour le prématuré en isolette. Chaque matin, l'infirmière fait une toilette complète à l'huile et revêt le bébé de vêtements stérilisés. Le régime est indiqué par le chef pédiatre. Quand le prématuré a atteint le poids de 2,200 gm. et qu'il va très bien, il est transféré dans une nursery spéciale dépendant de la chambre couveuse.

Le premier bain sera donné quand le bébé aura atteint 2,600 gm. Le bain est alterné pendant dix jours encore avec la toilette à l'huile, ainsi bébé a le temps de s'habituer progressivement à ce nouveau mode de toilette.

Dans la chambre couveuse, nous avons des coupoles à oxygène en plexiglas, munies d'un thermomètre qui indique la température intérieure de la coupole. L'oxygène sortant de la bonbonne s'humidifie dans l'eau avant d'arriver dans l'oxycoupole. Il est indispensable que la bonbonne ait un *manodétenteur* qui indique le contenu d'oxygène et le débit-minute.

L'oxycoupole est munie en plus d'une réglette mobile à trois trous de grandeur différentes, une légère circulation d'air empêche ainsi la buée tout en permettant l'échappement de l'air vicié. Dans la chambre couveuse, le prématuré reçoit de l'oxygène jusqu'à ce qu'il supporte l'air ambiant. On supprimera progressivement l'oxygène en enlevant l'oxycoupole une demi-heure, puis une heure et ainsi de suite. L'oxycoupole, après l'emploi, est désinfectée soigneusement au désogène à 5 pour cent.

Le désogène n'attaque pas le plexiglas.

Les humidificateurs contiennent de *l'eau distillée* et non de l'eau calcareuse qui rendrait le plexiglas opaque. Il faut veiller à remplir régulièrement les humidificateurs.

Les mères qui ont accouché dans

Reproduit de *l'Infirmière* (oct. 1952), organe de la Fédération Nationale des Infirmières Belges. *L'Infirmière* doit cet article à l'obligeance de l'Oeuvre Nationale de l'Enfance. Mlle Oppliger est monitrice de la Maternité Universitaire de l'Hôpital St-Pierre, Bruxelles.

notre service et dont le bébé est à la section des prématurés sont placées dans un secteur spécial.

L'infirmière s'occupera dès le deuxième jour des soins des seins et de l'extraction du lait, soit au tire-lait électrique, ou au tire-lait suisse, ce tire-lait nous donnant particulièrement satisfaction dans ce cas.

Pour que la maman porte intérêt à son bébé, on la conduit chaque jour (sur chariot ou chaise roulante) près de la chambre couveuse où elle peut voir son petit à travers la vitre.

Quand la maman quitte la maternité le dixième jour, sans son bébé, celui-ci étant encore trop petit, le service lui prête le tire-lait suisse ainsi que deux ou trois biberons stériles. Chaque jour, on nous porte le lait qui est étiqueté, placé en glacière et destiné uniquement au bébé.

Le prématuré devenant plus vigoureux, l'infirmière convoquera la maman pour un essai de mise au sein. Si celui-ci réussit bien, la maman viendra deux ou trois fois par jour. Aux autres repas, le lait que la mère aura apporté sera donné au bébé.

Avant de donner le sein, la maman passe dans un vestiaire où elle se lave soigneusement les mains *(les ongles doivent être courts)*, enfile une blouse spéciale et met un masque.

Avant la sortie définitive du bébé, la maman vient assister plusieurs fois aux soins. Si l'enfant est nourri artificiellement, on apprend à la maman la façon de préparer le régime prescrit par le pédiatre.

D'autre part, l'infirmière d'hygiène sociale s'est rendue, avant la rentrée du bébé, à son domicile pour vérifier si la mère a bien tout préparé pour le retour. Les jours suivants, elle rendra visite à la mère et pourra ainsi se rendre compte si les conseils donnés ont été compris et appliqués. Elle restera en contact avec la mère pendant plusieurs mois.

Le Prematuré en Chambre avec la Maman

Il s'agit de bébés bien portants, pesant entre 2,200 et 2,500 gm. et pouvant, de ce fait, rester dans la chambre de la mère, sous certaines conditions.

A la naissance, ce bébé reçoit les mêmes soins que le prématuré destiné à la chambre couveuse. On lui met la même layette. Le berceau est également chauffé d'avance mais, en plus, ce berceau est protégé de tous côtés par de petits draps spéciaux qui y sont fixés. Il est mis dans un coin de la chambre bien à l'abri et entouré d'un paravent. Un deuxième paravent est placé près de la fenêtre. Au radiateur est fixé un humidificateur.

L'infirmière aura expliqué à la maman que les visiteurs ne peuvent s'approcher du berceau et, encore moins, toucher le bébé. Dans l'intérêt du bébé, les visites seront limitées. La température de la chambre sera surveillée (22 à 24° C.).

Tout le matériel s'y trouvera: balance, table de change, ainsi que le linge et layettes stériles, médicaments, etc. Le bébé ne sort pas de la chambre.

La toilette à l'huile est faite tous les matins — technique de ces soins:

Layette stérile chauffée.

Huile chauffée au bain-marie ou près du radiateur (huile d'arachide).

Boite avec cigarettes d'ouate stérile.

Bac réniforme, seau pour linge souillé.

Toile caoutchoutée de rechange pour le berceau.

Médicaments:

Collyre à l'oxycyanure de mercure à 1/5,000.

Sycombile pour soins du cordon ombilical.

Thermomètre trempant dans récipient + désogène à 5%.

Poudre astreptine en cas de besoin.

Alcool iodé à 3% en cas de besoin.

Pince à pansements, boite avec pansements.

Petit bol stérile + eau tiède.

Il est important que tout soit prêt d'avance. Jamais l'infirmière ne doit quitter la chambre sous prétexte d'avoir oublié quoi que ce soit.

1. L'infirmière se désinfecte les mains. Le bébé est posé sur la table de soins.

2. Vérification des *yeux*. S'il n'y a pas de suintement, on n'y touche pas.

3. Soins du *nez*. Ceci est très important. Les sécrétions nasales se dessèchent au bout de deux jours, le bébé respire mal, renifle et éprouve des

difficultés à prendre le sein. Prendre une fine cigarette d'ouate, la tremper dans l'huile, l'introduire dans la narine en tournant légèrement et en suivant le conduit nasal d'avant en arrière. Même procédé pour l'autre narine. Ne jamais se servir d'allumettes ou de stylet monté d'ouate. C'est trop dangereux.

4. Soins des *oreilles*. Avec une cigarette d'ouate imbibée d'huile, on nettoie sans appuyer et très légèrement le conduit auditif, ainsi que les plis du pavillon et derrière l'oreille.

La *bouche* ne se lave jamais, la salive la tient propre.

Défaire ensuite le maillot; en cas de selle, laver le siège avec l'eau tiède et ouate. Prendre la température (rectale) du bébé. Le recouvrir et se laver à nouveau les mains.

Déshabiller complètement le bébé, l'envelopper dans un lange chauffé, l'examiner soigneusement pour contrôler l'état de la peau.

Peser ensuite le bébé *bien recouvert* par le lange. Puis commencer la toilette.

Un premier tampon d'ouate trempé dans l'huile. On lave le front, ailes du nez, joues, tempes, menton et pourtour de la bouche, renverser doucement la tête en arrière pour déplisser la peau du cou, laver celui-ci, puis le crâne.

Un deuxième tampon bien imbibé d'huile servira à laver les petits doigts, mains (bien ouvertes), puis les bras, aisselles (bien soulever les bras sinon il se produit de la macération dans ces plis), thorax, nuque et dos.

Mettre le petit corsage d'ouate, puis la chemise, pour éviter le refroidissement du bébé.

Un troisième tampon d'ouate imbibé d'huile sert à laver les pieds, les jambes, les cuisses, le pubis, les plis de l'aine, les lombes, le siège. Pour les organes génitaux, on prendra un quatrième tampon toujours imbibé d'huile.

Se laver les mains une fois de plus pour donner les soins au cordon ombilical, placer la bande sans la serrer. Mettre les chaussons, le maillot, puis le bonnet et les mouflettes.

A partir du quatrième jour, on fera la toilette en présence de la maman et en lui donnant des explications. Le bébé doit porter le maillot jour et nuit.

Après 24 heures, la bouillotte est supprimée mais une couverture de laine spéciale qui a l'avantage d'être très légère mais bien chaude recouvre le berceau ainsi qu'un léger duvet.

Grâce à toutes ces précautions, aucun de nos petits bébés n'a fait de l'hypothermie.

En été, s'il fait très chaud, on enlève le duvet pendant la journée. Pour ces détails, l'infirmière doit faire preuve de bon sens.

L'Alimentation

Les premières 24 heures, le bébé restera à jeun. S'il pleure fort la nuit, on lui donne un peu d'eau lactosée à boire. Après 24 heures, bébé est mis au sein et pesé avant et après. S'il boit, on le mettra au sein toutes les trois heures, sinon deux ou trois fois seulement pour l'habituer. S'il n'a rien bu, on lui donnera du lait maternel écrémé au biberon. Nous possédons toujours une réserve de lait maternel contrôlé. Si la maman est primipare, il faut prendre patience les premiers jours jusqu'à la montée laiteuse.

Les tétées doivent être surveillées de près; elles seront au nombre de six à intervalle de trois heures. Les six premières nuits, le bébé reçoit du lait maternel, à 24 et à 3 heures, qu'il boit d'ailleurs toujours très bien.

A partir de la septième nuit, s'il grossit régulièrement, il ne recevra plus qu'un biberon de lait maternel *et seulement s'il pleure*.

Nous tâchons, dans la mesure du possible, que la maman, une fois rentrée chez elle, ne doive plus donner à boire la nuit.

Si elle est bonne nourrice et si le bébé crie trop la nuit, elle peut lui donner le sein une fois, et pendant quelques nuits seulement.

Il arrive que le bébé soit atteint de jaunisse. Il est somnolent, prend plus difficilement le sein. Vers le cinquième et le sixième jour, il va généralement mieux. Il vaut mieux, dans ce cas, vider les seins au tire-lait et donner le lait au biberon.

Nous conseillons aux mamans de rester quelques jours de plus à la

Maternité dans l'intérêt du bébé. Toutefois, nous les encourageons à faire une promenade de une à deux heures pendant l'après-midi.

Au début, l'infirmière d'hygiène sociale ira faire visite à la mère et à l'enfant chaque jour.

Pendant trois semaines, la maman lavera le bébé encore à l'huile. Sur ces entrefaites, il augmentera en poids et recevra alors son premier bain, donné sous la direction de l'infirmière d'hygiène sociale.

Le bébé ne peut pas venir à la Consultation pour Nourrissons avant d'avoir atteint le poids de 2,800 gm. Pendant la période intermédiaire entre leur sortie de la maternité et les visites à la C.N., il est conseillé aux mamans de louer un pèse-bébé.

Façon de Donner le Biberon

Le bébé est changé, on lui place une petite serviette sous le menton. L'infirmière est assise et le tient dans son bras gauche, légèrement soulevé.

Si on donne du babeurre, celui-ci doit être chauffé au bain-marie, la température ne peut pas dépasser 38° C., sinon il se coagule.

Il est aussi important que le trou de la tétine ne soit ni trop grand ni trop petit. Nous perforons la tétine avec une fine aiguille, no. 10, portée au rouge. Le lait doit s'écouler de la tétine en fin jet. Si le trou est trop grand, bébé boit trop vite, avale de travers et finit par tout vomir. Si le trou est trop petit, il se fatigue vite et finit par s'endormir.

La tétine doit être posée entre le palais et *sur la langue*. L'infirmière veille aussi à ce que la tétine n'obstrue pas complètement la bouche du bébé, sinon il boit difficilement.

Si, après quelques minutes, bébé se fatigue, laissez-le se reposer un peu (mettre le biberon dans le récipient qui contient de l'eau chaude pour éviter le refroidissement rapide du lait).

Tenir le bébé droit, parfois il régurgite de l'air. Lui donner ensuite le restant du repas.

L'infirmière doit veiller à ce qu'il vide le biberon en vingt minutes. Pour finir, le tenir droit et lui laisser faire les derniers renvois. Pour l'aider, on peut lui tapoter légèrement le haut du dos.

Les régimes sont préparés à la biberonnerie centrale sous la surveillance d'une infirmière-chef spécialisée en diététique infantile.

Entretien du Materiel

Chaque jour, les tétines, sondes et gobelets, seringues sont savonnés, rincés et bouillis dans de l'eau distillée fraiche. Les biberons sont stérilisés à l'autoclave à la biberonnerie centrale.

Entretien de la Chambre Couveuse et de la Nursery Attenante

Table de change, toiles caoutchoutées, baignoire, etc., doivent être nettoyées journellement avec un linge propre bouilli que est trempé dans une solution de désogène à 5 pour cent renouvelée chaque matin.

Le bac réniforme est désinfecté ainsi que le seau à linge et à pansement avec un essuie qui sera ensuite lavé et bouilli.

Les éviers, qui pullulent de microbes, sont savonnés et désinfectés au Dettol avec une lavette spéciale réservée exclusivement à cet usage.

Perhaps the most valuable single device in rehabilitation of the hypertensive patient is psychotherapy; the planned and detailed methods employed by the psychiatrist are not necessarily superior to repeated conferences with a sympathetic physician who will give attention to problems responsible for emotional instability. A physician properly trained in general medicine and with an interest in psychiatry is competent to undertake such treatment and beneficial results are often obtained in a relatively short time. Simple, sympathetic reassurance is often sufficient to relieve disturbing symptoms. The physician can foster this attitude by prolonging the interval between examinations, particularly in the early uncomplicated period when symptoms are few or absent. Psychotherapy intelligently applied often results in dissipation of the anxiety, depression, and irritability which accompany the phobia of high blood pressure.

—Dr. Wm. Goldring

The Special Nurse

HAZEL WALSH

I ENTERED THE FRONT DOOR of the hospital with a good deal of trepidation and asked the desk clerk where I would locate the office of the superintendent of nurses. She evidently thought my vision was defective since the name was written clearly above a door right opposite the main entrance. Moistening my lips I approached the door, knocked and was invited to come in. The nurse behind the desk looked at me inquiringly and I stated that I was the nurse sent from the Private Duty Directory for Mrs. Brown. I was handed a ledger the page of which was itemized with the headings: Date, duty hours, nurse's name, patient's name, room number, and doctor's name. I filled in the necessary information, backed out, and headed for the elevator.

In the past five years I have visited a number of countries, worked in numerous hospitals, lived and worked with nurses from a variety of schools of nursing, yet each time I enter a hospital that is strange to me I go through this agony of uncertainty and apprehension. I know that similar methods in the routine care of the sick are carried out the world over—how conscientiously depending upon the individual nurse. But I also know that a strange nurse is looked upon with some misgivings by a great number of regular staff nurses.

Since I was the first nurse on this particular case it was necessary for me to approach the floor supervisor to obtain records, report, and treatment for my patient. She may welcome me graciously, inquire if I have worked here before and, finding I am new, take considerable pains to help me become thoroughly oriented. Then again she may simply heave a martyrish sigh which loudly indicates that no nurse could possibly be any good unless she was born, bred, and prepared to be buried in this particular town, point in the general direction of the chart files and leave me to sweat it out. If the supervisor is the right person in the right place her manner would put me at ease at once. If she is the other kind my dander would be up and I start thinking, "To . . . with them anyhow!"

Having acquainted myself to the best of my ability with the patient's history, condition, and treatments pending, the next step is to meet my patient. By this time all feeling of panic and uncertainty miraculously disappears and, with everything under control, I tap on the patient's door and enter.

A terrific amount depends on this meeting. He or she may like you or they may not. This is one job in which it just doesn't do to get a swelled head. For weeks, perhaps months, a nurse may attend numerous patients with various ills and know that she has made a good friend in each one. Then one day she walks into a room and, in less than no time, knows that she had better relinquish the case. If she doesn't her patient will replace her anyhow. This happens to the best of us.

Since I am fully responsible for the treatment and welfare of my patient for the next eight hours I try to find out his personal likes and prejudices. In this day and age of chain smokers it is remarkable how many patients express relief when they find their nurse is a non-smoker. Though they may be a slave to the weed when in good health, during an illness patients are usually off their smokes and are repelled if there is an odor of stale tobacco exuding from the nurse's person. For all that, an occasion is still green in my memory when I was told my services were no longer required because I declined to smoke a cigarette with my patient each time he felt like having a puff.

A special nurse is usually called in at the doctor's request. Since it is the

Miss Walsh practises her profession in Vancouver.

patient's obligation to pay her fee the matter is no doubt discussed between the doctor and patient. When the patient is on the high road to recovery the doctor suggests that he can now dispense with his special nurse but if the extra expense is of no importance the patient may retain her services.

The doctor can make or mar the equanimity of a special. She is in such close contact with the patient that she invariably anticipates his needs. Most doctors rely upon her to draw their attention to any minor treatment required to aid recovery. They are always ready to order any practical treatment or medication but those orders cannot be carried out unless they are written in a regulation order book and *signed*. Full of wisdom is the nurse who sticks closely to the doctor until he has written his order albeit it is likely to be completely illegible!

For the nurse who wants to widen her horizon by seeking fresh fields, special or private duty is her best occupation to follow. It is seldom a patient is in need of a special for too long a period. In every place I have visited I have found that, if you have adequate proof that you are a genuine registered nurse, opportunities for work are plentiful. In the larger hospitals in British Columbia, in each of which there is a school for student nurses, a nurse must hold her B.C. registration before she will be accepted on the staff or as a special or private duty nurse. Therefore registered nurses from other states, provinces, or countries usually comply with these regulations. Should the transient nurse feel that her stay here doesn't warrant that proceeding, she can find work in the smaller hospitals, nursing homes or in private homes. To hold the qualifications of a registered nurse is the greatest armor and shield a woman can possess to face the world. Her world lies there in those masses of stone, brick and mortar that house the sick. The buildings I have looked at in different cities and countries fill me with no trepidation. But when I enter the front door of a hospital, anywhere, waves of panic and apprehension sweep over me and I wonder, "What are the nurses like within this little world? How will they treat the stranger within the gates?"

Levels of Maturity

Delegation of authority and responsibility is made more constructive if we keep in mind this series of stages of personality development that characterize successive periods of growth, having special reference to the sense of personal responsibility in interpersonal relations:

1. *Infantile level*: At this level one expects from others an unlimited amount of service and consideration with no feeling of reciprocal obligation.

2. *Childish level:* Here is some sense of responsibility but it is delegated responsibility that is completely erased by a good excuse. The alibi habit is characteristic of this level.

3. *Early adolescent level:* At this level there is a strong need to attain personal significance. There are strivings for support outside the family, identification with groups, and idealistic hero worship. The great emotional need is for assurance as to personal significance.

4. *Late adolescent level:* There is a sense of social responsibility in the form of loyalty to a cause as well as to a group or person. Sexual interests are expressed in pairing off and courtship behavior but success in that field has the emotional quality of a conquest rather than of mutual devotion.

5. *The adult level:* Personal maturity is shown in a balanced perspective regarding one's self and one's life work in relation to others. The mature person is self assured, and without feelings of being threatened. He can handle a number of social roles and can shift himself from one to the other without anxiety.

By understanding these levels of maturity in ourselves and others, our interpersonal relationships will be more constructive in that they are based on the individual's own system of values.

—*Digest of Treatment*, July, 1952.

Start filling your piggy bank for "Banff in '54."

Student Nurses

Nurses as Film Stars

BEVERLEY WHITE

EARLY LAST YEAR the McMaster University School of Nursing decided to film a movie of their nursing course in order to bring before the people of Hamilton and Ontario the pictorial presentation of a new, fascinating course of study in nursing. We, as undergraduates, were thrilled to take part in this novel, interesting work. I must admit that, as nurses, we were not especially proficient in the arts and skills of acting. However, it did present a challenge for us.

Since in the course of our five-year training program we travel far and wide to various affiliating institutions, our film producers followed hither and yon at our heels to "shoot the run" on the actual sites of operation. Many times we thought that we would never be free, for we were tagged on the wards, in the classrooms, at the dances and sports events, and on the campus. Now that we are finished, we can sit back, relax and laugh at our mistakes — especially during the "sneak previews."

The other night, while pondering how to write this article, I sat down in my favorite chair, turned the lights down low and drew from the tablets of my memory all the experiences of the past year. Many of the adventures stood apart as farcical comedy and buffoonery while other incidents were tinged with tension and apprehension.

As the process of retrospect slowly wove its way into the dusty past, my thoughts turned to that first eventful day as we stood before the cameramen — nervous, excited, unnatural and awkward. We had so many fine points to remember about acting that, at times, we lost sight of the project in hand. Often some observers would shout out, "More action, students! This filmstrip doesn't last forever!" Continually they would remind us not to turn our backs to the camera and to always put our best foot forward. Sometimes film technicalities became so confusing that we were filled with disgust and despair, for who could do things lefthandedly when for the past 20 years you had been doing a good job with your right? All this was due to the fact that the lighting was poor in the other direction. Likewise, it was difficult to conceal that smug smile when your favorite classmate was delegated to be the patient for a Wangensteen demonstration!

Since our first two years of nursing are spent on the university campus we felt that much of the film should depict scenes of that period of training. Displaying our best and worst events, we chose a group of nurses passing through registration and the subsequent initiations. Those students who had survived this era laughed heartily at the profound embarrassment of these newcomers caught in their gaudy attire. At the sports events we were filmed during the most uncomplimentary moments — there we stood clad in old plaid shirts and faded jeans, cheering hysterically, munching the succulent hot dog, and acting like wild Indians — displaying anything but the professional ethics so highly stressed in our training.

We must admit, however, that the

Produced by two enthusiastic amateur movie makers of Hamilton, Ont., who sponsored and financed the work, this 16-millimetre film will be shown in various secondary schools in Ontario to give potential student nurses a preview of the work of a nursing school. The script for this documentary film was written by members of the staff of McMaster University School of Nursing.

informal events were less nerve-racking than the more prepared film runs. Our only consolation was the fact that the supervisors were as nervous as the students and we were all subject to correction and direction. In filming our co-educational classes, our major problem was to recruit the necessary manpower, for the boys were inclined to be bashful and self-conscious. I remember one night when I was asked to exercise my persuasive powers in pressing some lads into service. As I approached them in the library, they eyed me warily, sensing that something was strangely amiss. At first they were all anxious to participate but as they stepped before the lights they suddenly lost heart. Why, everyone would think that they were nurses!

As the days passed by, we felt more at ease with ourselves. The "cheesy" smile soon melted down; the conscious, awkward movements changed to natural, rhythmical actions. Our stage fright drifted away with many other worries. Even the lecturers grew accustomed to the periodic interruptions by the film experts. Often I reflect back to the nights that we worked on our projects. There we stood, criticized by the director, producer, and film technicians as the bright, blinding lights beat down on our heads and burned at our sensitive eyes. At the time, I wondered whether it was worth all the trouble. Now I know that the project built up our school pride, inspired teamwork and, above all, gave us something to remember for the rest of our lives.

It was important that theoretical as well as practical subjects be included in the film and in due time all courses related primarily to university studies were covered. From our bacteriology labs. came scenes of white-frocked girls busily inspecting agar plates and tracking down "deadly pathogens" with the aid of powerful microscopes. In anatomy and physiology classes we proudly displayed "George" and "Josephine" — pet skeletons in our locked nursing closet. Chemistry, too, received its share of attention. There, before our very eyes, transparent solutions turned to multicolored concoctions by the mere addition of some mysterious brew and a quick stirring movement of a beater.

When the casting was completed at university the next step was to move out into the community, to the various institutions and specialized departments of learning. Each class had its chance to show the world how it performed while it worked. As third-year students, my class had the opportunity to be filmed at the Ontario Hospital, where we were studying psychiatric nursing for three months. Later, as we journeyed to the Hamilton General Hospital, scenes were taken during doctors' lectures, at classroom demonstrations, and while performing ward activities.

Our senior classmates were followed through their surgical training to the operating room and to the Sanatorium and Mount Hamilton Maternity hospitals, where they were affiliating. Of course, during the movie many patients and onlookers became involved in the filming, and I must say that they were indispensable. Most of the people were happy to help us spread the idea of nursing education to the public and especially to see themselves on the screen. I remember how heartily we laughed to hear of the patient who had been filmed in the operating room. It seems that there is no longer any privacy, for if it isn't television operations, it's movie films.

Part of our nursing experience extends into the field of community nursing and naturally we have many cherished memories of afternoon field trips to nearby towns. How proudly we clambered into our new station wagon as the film camera clicked off the pictures. Likewise, we waved gleefully as we entered the little Austins of the V.O.N. for a busy day on the "rounds."

The happiest memory of all the year came last May as we watched our graduates march slowly across the campus in their majestic procession. Surrounded by smiling parents, old friends and the ever-present photographer, the girls looked very happy to have reached that

long-awaited day when they could proudly wear their robes with trimming of blue and gold, symbolic of their science degree in nursing.

Yes, as I thought back over a year of hard work, I felt proud of a job well done. We had been successful, enjoyed ourselves as film stars, and added the variety that is the very spice of life. No doubt we will boast of our acting ability to our grandchildren!

If you have the opportunity to see our 30-minute movie, do make the effort. It will revive old school day memories, bring forth a few hearty chuckles and, above all, broaden your outlook on modern nursing education. We hope it will inspire many young girls to follow in our footsteps and bring before the public some of the experiences encountered along the royal road of learning in nursing.

How to Remove Fishhooks

The average angler is a careful individual but millions of fishhooks are used each summer by thousands of anglers. Accidents will sometimes occur and the angler instead of the fish will be the one to "get hooked."

A fishhook is well designed for the purpose of quickly penetrating a fish's flesh . . . and staying there. Fish don't have so many live nerves as humans. Having learned that fact we remove the hook from a fish with little concern.

But when a fishhook is imbedded in human flesh, there's a difference. There are countless nerves yelling for help and relief and human flesh is subject to infection.

Trying to remove a fishhook from the human body by pulling it out backwards when it has penetrated the flesh beyond the barb is at once painful, seldom successful, or will cause a large, jagged wound.

One of the best methods of removing a fishhook from human flesh, approved by physicians and recommended by Department of Lands and Forests conservation officers, is as follows:

First, study the wound for a moment and decide the best direction to point the hook to force it on through the flesh without striking anything vulnerable, such as a bone or blood vessel.

Carefully and firmly turn the point of the hook to the direction decided upon and force it right through the flesh with a quick, controlled motion. When the barb is free outside the flesh, cut off barbed point with a pair of sharp side-cutting pliers (a pair of which is a must in every tackle box) and withdraw the remainder of the hook backward the way it went in.

Fishhook* wounds are very likely to become infected. To allow the cut to dry up and close on the surface while possible germs remain imbedded inside is to invite infection. That is bad enough when modern medical aid is available but is far worse when one is away off in the bush many miles from such care.

The wound should be encouraged to bleed for a while after the fishhook has been removed. This will relieve the wound of some of the dirt and possible germs. It should then be sterilized with alcohol from your first-aid kit or a little iodine (but not enough to cause an iodine burn). Never place adhesive over a fishhook wound or cover it with greasy ointment. The best treatment, after encouraging the wound to bleed for a time, is to cover it with a moist boracic dressing. Keep the dressing moist and change it frequently. See a doctor as soon as you can.

—Ontario Government Services

Epidemic-Warning Service

WHO provides an intelligence service for the detection of epidemics. World-wide broadcasting facilities warn governments of the appearance of epidemics in any part of the world, measures taken to halt them, and steps needed for immediate protection.

The WHO World Influenza Centre in London, key point of a world-wide network of influenza centres, detects new epidemics, identifies viruses, and prepares vaccines.

Nursing Profiles

THE NEW CENTRALIZED lecture program for student nurses that began to operate in Saskatchewan at the beginning of this year is the fulfilment of a cherished dream. Over-all planner, coordinator and adviser to schools of nursing for this, the first such program to evolve in Canada, is **Hazel Bernice Keeler** who has been director of nursing education at the University of Saskatchewan for the past three years.

A native daughter of that province, Miss Keeler had already earned her B.A. degree at the University of Saskatchewan before enrolling at the Vancouver General Hospital for her training in nursing. Following graduation she went to the Kootenay Lake General Hospital, Nelson, B.C., as obstetrical supervisor. Two years later she enrolled in the McGill School for Graduate Nurses to secure her certificate in teaching and supervision. Returning to her home school, Miss Keeler served as science instructor for four years before going to the University Hospital in Edmonton as a clinical instructor.

Her next step up the professional ladder took Miss Keeler to the Women's College Hospital, Toronto, as director of nursing. When the department of nursing education was organized at the University of Manitoba she became the first director. In 1948 she became associate professor of nursing education at the University of Buffalo, N.Y. She returned to Saskatchewan two years later to assume the directorship of the university nursing program.

Always progressive and farsighted, Miss Keeler reorganized the work in the school of nursing at University of Saskatchewan to provide for the inclusion of specialized training in public health nursing within the framework of the five-year degree course.

In order to meet the problem of the geographical distribution of the schools of nursing, the new centralized program has been organized in two areas. Gertrude Mae James is director of the Saskatoon Centre, with Lucy Dorothea Willis as director in Regina. Each of them has a corps of instructors and supervisors who will also integrate the theory with the practice in the students' home schools.

Esquire Photo, Saskatoon

HAZEL B. KEELER

GERTRUDE JAMES

Gertrude James was born in Biggar, Sask., of Irish-English parentage. She received her nurse's training at the Royal Alexandra Hospital, Edmonton. Soon after graduating she enlisted with the Royal Canadian Army Medical Corps and served overseas for over two years during World War II. Discharged from the service in 1946, Miss James entered the McGill School

for Graduate Nurses. After receiving her Bachelor of Nursing degree there, she joined the teaching staff of Saskatoon City Hospital as science instructor, moving on to become educational and social director there. Last year she completed the requirements for her Master of Arts degree at Teachers College, Columbia University, New York.

Miss James is a member of the Order of the Eastern Star. She enjoys a variety of handicrafts and, when time permits, is active in sport.

New Hollywood Studios, Saskatoon

LUCY WILLIS

Lucy Willis comes of Scottish ancestry. Born and educated in Moose Jaw, Sask., she graduated from Toronto Western Hospital in 1942. A year as junior instructor at the Moose Jaw General Hospital preceded her enrolment at the University of British Columbia where she secured her certificate in teaching and supervision. Miss Willis joined the staff of the Saskatoon City Hospital serving successively as head nurse, clinical instructor, nursing arts instructor and educational director. She organized the program of the social director combining it most effectively with her educational duties.

In 1950 Miss Willis received a W. K. Kellogg Foundation Fellowship. She enrolled at Teachers College, Columbia University, and completed the requirements for both her B.S. and M.A. in the next two years. She is a member of two honor societies in education—Pi Lambda Theta and Kappa Delta Pi. She is also a member of the Business and Professional Women's Club. Stamp collecting, poster painting, knitting, sewing help to while away the spare hours. For several years she was leader of a children's mid-week church group—the "Explorers." No longer living in residence, Miss Willis is having lots of fun interpreting a recipe book.

ELIZABETH REED

Mary Elizabeth Reed has assumed her new duties as assistant superintendent of the Victorian Order of Nurses for Canada, a post for which she is eminently fitted by her years of professional training and experience. Born and educated in Saint John, N.B., Miss Reed graduated from the General Hospital in that city and engaged for a brief period in private nursing. She had served for 12 years as staff, then charge nurse with the V.O.N. in several centres in the Maritimes before she enlisted with the R.C.A.M.C. in World War II. She went overseas with No. 21 C.G.H. and saw service in Europe. During the last two years she was on the staff of the Matron-in-Chief (Overseas) at Canadian Military Headquarters in London. She was awarded the Royal Red Cross, second class, for her devoted work.

Returning to civilian activities, Miss Reed found her niche as a national office supervisor with the V.O.N. To the nurses in her territory in Eastern Canada she brought a sterling leadership. Since then she has found time to work for her bachelor's

degree from Teachers College, Columbia University. She majored in administration and guidance—both valuable avenues along which she will move in the course of her new duties.

Paul Horsdal, Ottawa

DOROTHY MICKLEBOROUGH

Dorothy Helen Mickleborough has retired from the post that she has held for the past four years as assistant superintendent of the Victorian Order of Nurses for Canada, and from active nursing endeavor, to enjoy the salubrious climate and the salty breezes at Ganges, B.C.

Miss Mickleborough's work has led her far since she graduated from the Seattle General Hospital 35 years ago. She served for a brief period at the close of World War I with the American Army Nurse Corps then returned to her home hospital as supervisor of surgery. Returning to Canada, Miss Mickleborough served for four years as operating room supervisor and assistant superintendent at the Jubilee Hospital, Vernon, B.C. Post-graduate study at the University of Toronto School of Nursing was the prelude to her many years of activity in the field of public health nursing. She joined the Ontario Department of Health serving for two years as a staff nurse, then as supervisor for five years. She was appointed to the staff of the Victorian Order of Nurses as regional supervisor for Ontario in 1934, later carrying a similar responsibility in Western Canada. Altogether she was 18 years with the Order.

LAURA M. LAMBE

Laura Mary Lambe who, since 1949, was superintendent of nurses of the Metropolitan Hospital, Windsor, Ont., has retired from active nursing. With a friend as partner she has opened a gift shop in Wallaceburg, Ont.

A graduate of Wellesley Hospital, Toronto, and of the McGill School for Graduate Nurses in supervision in schools of nursing, Miss Lambe has had an interesting and active career in nursing. She served as night supervisor, then instructor in her home school for many years before transferring to a teaching position at the Peterborough Civic Hospital. In 1943 she joined the staff of the Women's College Hospital, Toronto, where, two years later, she became director of nursing. The success of the demonstration program at the Windsor hospital was due in no small measure to Miss Lambe's understanding cooperation and enthusiastic support of the project.

Lyla Gregory of the nursing staff of Lancaster (D.V.A.) Hospital, Saint John, N.B., has retired after establishing an exceptional record of service for Canada's veterans of two world wars.

Born in New Brunswick, Miss Gregory received her training in Newton, Mass. Shortly after graduation in 1917 she joined the Canadian Army Medical Corps and soon proceeded overseas. She was on the staff of several military hospitals in England, returning to Canada in 1919. Almost immediately she joined the soldiers' civil reestablishment service, the forerunner of today's Department of Veterans Affairs. After serving at River Glade and Fredericton she transferred to Lancaster Hospital in 1921. For the past six years Miss Gregory has been in charge of the surgical supply room.

Though this page has recorded the coming and going of many outstanding nurses in the past few years, we have not had a male nurse in our columns heretofore. **William Cross,** who has been deputy chief psychiatric male nurse at the Provincial Mental Hospital, Essondale, B.C., sets a precedent, therefore, as he retires after 39 years of faithful service in mental nursing. Mr. Cross joined the staff as an attendant in 1913. During World War I he served in Belgium and France with the Canadian Army Medical Corps, returning to mental work upon discharge. He is retaining his interest in this activity by serving as registrar for the B.C. Psychiatric Nurses' Association.

In Memoriam

Mary (Macdonald) Donovan, a graduate of The Montreal General Hospital, died in Montreal on February 21, 1953, at the age of 67.

* * *

Lenta G. Hall, who graduated from the Royal Victoria Hospital, Montreal, in 1924, died in Wolfville, N.S., on February 17, 1953, in her 59th year. Born in New Brunswick, Miss Hall taught school for nine years before entering upon her nurse's training. After securing her public health nursing certificate from the McGill School for Graduate Nurses, she joined the Halifax Branch of the Victorian Order of Nurses. She was district superintendent there for ten years, becoming eastern supervisor in the National Office of the Order in 1944. Miss Hall served one term as president of the Registered Nurses' Association of Nova Scotia.

* * *

Bertha Isabel (Atkinson) McLellan, who graduated from the Lady Stanley Institute, Ottawa, in 1903, died at her home in Whitby, Ont., on February 3, 1953, in her 78th year.

* * *

Isabel Moodie, who graduated from the Toronto General Hospital in 1899, died in 1952, at the age of 82.

* * *

Annie Effie Moyer, who graduated from the Mack Training School, St. Catharines (Ont.) General Hospital in 1912, died there recently. Miss Moyer had engaged in private nursing all of her professional life, retiring a short time ago.

* * *

Janet Neilson, who graduated from the Toronto General Hospital in 1896, died in Collingwood, Ont., on February 4, 1953, at the age of 79. Following graduation, Miss Neilson spent some time in private nursing before joining the staff of the Sanatorium at Weston, Ont., to study the care of tubercular patients. In 1907 she was appointed as the first public health nurse in Toronto in charge of the new chest clinic. Soon after the city's Department of Public Health was organized in 1912, Miss Neilson was made the superintendent of North Toronto District, a post she held until her retirement in 1944.

* * *

Annie Simson Rathbone, who was the first district nurse with the Margaret Scott Mission in Winnipeg, joining it in 1896, and a former matron of Ninette (Man.) Sanatorium, died in Winnipeg on January

A. D. Skilling

JANET NEILSON

12, 1953, at the age of 80. Born in Nova Scotia, Miss Rathbone went west soon after her graduation from the Massachusetts General Hospital in Boston. During World War I she served overseas with the American Army nursing service, settling in Gibson's, B.C., on her discharge.

* * *

Fanny S. Sayre, who graduated from St. Luke's Hospital, Spokane, Wash., in 1909, died in Vancouver on January 3, 1953. Born in New Brunswick, Miss Sayre served overseas during World War I. Most of her professional life she did private nursing.

* * *

Hazel (Morrison) Wadman, a graduate of the Moncton (N.B.) Hospital, died recently in Moncton. After graduation, Mrs. Wadman worked as a doctor's nurse for several years. She maintained an active interest in nursing affairs, being a member of the New Brunswick Association of Registered Nurses and also of the Nurses Hospital Aid in Moncton.

Teaching Fellowships in Medical-Surgical Nursing

THREE TEACHING FELLOWSHIPS will be available for graduate nurses wishing to study for the degree of Master of Science in Nursing with a major in nursing education in the teaching of medical-surgical nursing.

Qualifications: Nurses must be eligible for admission to the Nursing Department of the Graduate School of Wayne University and they should have had several years of good experience in nursing service or education. Throughout the period of the Fellowship, they must elect work in, and remain in good standing in, the Graduate School of Wayne University.

Responsibilities: The graduate fellows will be assigned for 20 hours per week to assist with the supervision of basic students who are having their nursing practice in medical-surgical nursing. They will work under the direction of Associate Professor Irene Beland. They may attend faculty meetings and participate in the general activities of this group. The other half of their time will be utilized in part-time study in the Master's Degree program in nursing education in the Graduate School. It is expected that a minimum of eight credit hours per semester will be carried. Summers will be free unless special arrangements are made with the fellows for extra assignments for which additional remuneration will be given.

Financial remuneration: Each fellow is paid $1,600 for the academic year from September through June. Tuition and the non-resident fee are waived during the academic year throughout the period of the fellowship. Incidental fees must be paid by the fellow.

Length of appointment: Appointments are made for an academic year only but it is understood that, if the appointment is mutually satisfactory, it will be renewed for a second year in order to allow the fellow to complete the requirements for the degree of Master of Science in Nursing.

For further information and application forms, write to: **Dean, College of Nursing, Wayne University, 5257 Cass Avenue, Detroit 2, Michigan.**

℞ Chuckles, P.R.N.

The Bundle of His could be located in the kidney, brain or capillary network.

Spina bifida is a condition in babies where the spine is cleft in two at its base.

The gall bladder is an accessory organ of reproduction.

A function of the skin is to make us look better.

An embolus is an opening between the auricles of a fetal heart.

Ophthalmia neonatorum means the sight of newborn infants. They are unable to determine objects but they can differentiate light from dark.

Version refers to a displaced uterus being either recte verted or ante verted.

The function of white blood cells is to:

1. Make leukocytes.
2. Engulf red blood cells.

The greater trochanter is a muscle that moves when we breathe.

The "pacemaker" node does not allow too much lymph fluid into the tissues.

Trends in Nursing

C.N.A. Executive Meeting

MANY IMPORTANT and instructive items of business were discussed at the very well attended meeting of the governing body of the Canadian Nurses' Association held in Montreal in February. In order that everyone may be familiar with the way our professional affairs are shaping up at the National level, a brief summary of some of the principal topics follows here.

Though the National body functions in a purely advisory capacity to the provincial associations, it is our observation that sooner or later the trends become incorporated in provincial action. It is well, therefore, for all of us to follow the direction of straws in the wind. Where is professional nursing in Canada tending in this spring of 1953?

Structure Study

As yet the membership of the C.N.A. has not adopted the recommendations set forth in the Structure Study carried out by Dr. Pauline Jewett. However, the intensive study being conducted throughout organized nursing in Canada is beginning to show results.

For the first time in far too many years our membership is becoming aware of the present Constitution and By-Laws of the C.N.A. There is no better way to familiarize oneself with present legislation than to have to come to some agreement about possible changes. This was very evident at the meeting of the Executive Committee — January 29, 30, 31 — in Montreal. Here preliminary steps were outlined in the procedure necessary to make required changes in the Constitution and By-Laws should all or part of the recommendations in the Structure Study report be adopted at the 1954 Biennial. The intense activity within each of the provincial associations was shown by the many questions and suggestions put forth by the delegates from the nine provinces. As a start had to be made somewhere, By-Law VIII came under critical survey and the proposed changes were studied with great care. This part deals with national and special committees which, of course, are of great interest and importance to all of us. If plans now being made for the 1954 Biennial are able to be implemented, we will all have an opportunity of seeing how a "horizontal" committee will function. The Program Committee hopes to arrange reports, discussions, and displays in such a way that they will demonstrate vividly how the six committees will function.

Banff

A miniature chamber of commerce was present at the Executive meetings in shape of the duo from Alberta — Miss Frances Ferguson and Mrs. Clara Van Dusen. With the green light given on the 1954 Biennial in Banff, no one could resist the enthusiasm of these ambassadors from the West. They really want us in Alberta and are planning, along with the others of the Committee on Arrangements, to allow us to enjoy to the full all the attractions the national parks and the province of Alberta have to offer.

By the way, did you know that as well as the much advertised glories of Banff and Jasper, Alberta has another national park? Waterton, in the southern part of the province, is considered by the connoisseur to be the finest gem of the crown. It is small but exquisite and set in the heart of the cattle country. Perhaps you can make it a part of your itinerary in June, 1954.

For some years now we have been developing our public relations program. The latest step is that the C.N.A. Executive has passed a resolution allowing "associate members" to register at the General Meeting in Banff. It is hoped that, with this change in policy, those very interested and interesting members of our provincial associations who are not members of the C.N.A. will have an opportunity to develop a greater understanding of and sympathy for our national policies. We all know

that, on the local level, some of the hardest workers for the profession are women who are no longer actively nursing. They frequently are asked to speak for us at the Local Council of Women, the Women's Institute, the Home and School or Parent Teachers' Association meetings. We will all welcome them in Banff. And if they or you would like to travel with non-nursing friends or relatives, husbands included, they may register at the Banff Springs Hotel along with you. While you are at the meetings brushing up on your professional knowledge, they can be out surveying the landscape and planning your later excursions.

Committee Activities

It was very evident that the national and special committees had not been idle. The Committee on Institutional Nursing has been very busy doing the preliminary work for a manual on Orientation. The Executive was so interested in the manner in which it is developing that they requested that it be prepared so that it would apply to all branches of nursing service.

The Committee on Educational Policy has suggested a committee to deal with the increasingly important problem of curricula for psychiatric nursing personnel. It hopes to survey needs in relation to personnel in order to give adequate care to the mentally ill.

Other committees are examining the Structure Study with a view to understanding the effect of it on their functions and responsibilities.

Head Nurse Study

Although the final report of the Head Nurse Study is not yet ready, Mr. G. H. Josie presented a verbal report to the Executive. The Research Division of the Department of National Health and Welfare is very pleased with the results obtained so far. They hope that the data secured will indicate methods of studying nursing activities that will not need the detailed statistical examination such as has been applied to this study. Some of the groundwork already done may be able to be modified for future use.

Civil Defence

The number of nurses who have taken Civil Defence courses must be reaching sizeable proportions. In the newsclippings that come into National Office on an average of twice a week there always seems to be mention of a new group being instructed. We hope that those nurses who, for some reason, have missed the opportunity to attend a series of classes will make a determined effort to be present next time. Either your provincial office or Civil Defence headquarters is a good place to get information about the time and location of the next course.

Workshop

The School of Nursing of McMaster University is planning a workshop from May 26-30 on "Helping Students Use Science in Nursing" under the leadership of Miss Laverne Thompson, R.N., M.A., M.S. Miss Thompson, from Teachers College, Columbia University, is the author of "Introduction to Microorganisms" published by Saunders, 1949. This should be a very interesting course, particularly now when so much emphasis is being placed on the integration of the sciences into clinical practice.

The Royal College of Nursing

In a recent newsletter received from the Royal College, considerable space was taken up with a report from the Sister Tutors' section concerning conditions of service for sister tutors. It was interesting to read that, although they did spend some time on living conditions, salaries, and other such provisions, their main objection was the lack of recognition of the truly educational character of their work.

So long as hospital authorities regard her as at best a crammer for the State examinations, or one who can be deflected upon occasion to help with unofficial courses for "nursing cadets," so long as the Area Nurse Training Committees think in terms of what they need to nurse the patients instead of what they can offer to students, so long will tutors continue to leave this branch of nursing.

Recognition of the educational function of the sister tutor is bound up with recognition of the student status of the nurse in training, and recent investigations show that, in the absence of this recognition, lies the greatest single cause of wastage from the tutors' ranks.

We were particularly interested in this in view of the emphasis now placed on professional nursing courses being educationally sound. Do we not sometimes lose track of the instructor's need to prepare and carry out the teaching necessary for this? Can she do so if she continues to be a "crammer" for examinations?

Commonwealth Scholarship

A British Commonwealth and Empire Nurses War Memorial Fund Scholarship is again being offered to a Canadian nurse. Last year the donors of the scholarship requested that the recipient be from the West coast. This time she is to be French-speaking or from one of the more French-speaking provinces. Interested C.N.A. members may apply through National Office for further information.

Rehabilitation Nursing

As an addition to the concept of nursing the "whole" patient, a group of instructors and supervisors from the Montreal area were given very concrete ideas about rehabilitation nursing at a recent two-day institute. In the best type of nursing care, early consideration is given to the prevention of contractures and deformities by correct posturing exercises and good body alignment, which can be applied alike to medical, surgical, orthopedic, or any other case requiring nursing care. The "activities of daily living" can be taught to handicapped patients on a progressive scale, so that they retain as much physical and mental independence as possible and escape some of the inevitable psychic trauma entailed in every illness.

For the severely handicapped, whose total care requires the combined efforts of many specialists in physical therapy, occupational therapy, social service, psychology, and vocational guidance, the patient can be returned to a full, useful life only if the services of all these persons are focused on the patient through a cooperative program under medical and nursing leadership. Miss Alice Morrissey, R.N., and Dr. Leo Dobrin of the Bellevue Medical Centre, Department of Physical Medicine and Rehabilitation, described such a service to the Montreal group. Discussion centred around methods by which the basic principles of this type of total nursing care can be given more emphasis in the nursing curriculum. Total nursing care was described as the nursing of the whole patient, seeking to return him from his state of acute illness to complete restoration of physical ability, personality, and full social capability.

A three-month post-graduate course in rehabilitation nursing is offered at the University Medical Centre, Bellevue Hospital, New York City, under the leadership of Miss Morrissey. It fits the interested nurse for the practice and teaching of rehabilitation nursing, the coordination of the team personnel, and leadership in this type of nursing.

Refresher Course

The University of Toronto has presented a three-day refresher course for registered nurses—"The Health Needs of the Student of Junior and Senior High School Age."

Contributing to the presentation of the subject were the nurse, the physician, the psychiatrist, the psychologist, the social worker, the teacher, the parent, and the student herself.

Why Doesn't Everyone have a Cold ?

To catch a cold is a difficult thing researchers have found. Even when directly exposed to sneezing, runny-nosed patients, or objects contaminated with cold virus, only an insignificant percentage of people develop cold symptoms. The key factor seems to be individual susceptibility at the time of exposure.—*Lancet*, 263: 657, 1952.

Orientation et Tendances en Nursing

Assemblee du Conseil Executif de l'Association des Infirmieres Canadiennes

Durant l'assemblee tenue à Montréal les membres du Conseil Exécutif discutèrent de bien des points importants et instructifs. Afin que toutes connaissent le courant que prennent nos affaires professionnelles nous donnons dans ces colonnes un résumé des activités.

Bien que l'association nationale ne fonctionne qu'à titre d'aviseur envers les associations provinciales, c'est l'observation de ce qui se fait dans tout le Canada, qui, tôt ou tard, est adopté par les provinces. Il est donc à propos d'observer d'où vient le vent, vers quels horizons se dirige le nursing professionnel au printemps de 1953?

Etude de la Structure de l'A.I.C.

A date, les membres de l'A.I.C. n'ont pas accepté les recommandations faites par le Dr. P. Jewett dans le rapport de l'Etude de la Structure de l'A.I.C. Tout de même l'étude intensive qui est faite de ce rapport par tout le Canada commence à donner des résultats.

Pour la première fois depuis bien des années nos membres prennent forcement connaissance des constitutions et règlements de l'A.I.C. Il n'y a pas de meilleurs moyens de se familiariser avec les règlements que d'en discuter les changements à y apporter. Ceci était très évident lors de l'assemblée du Comité Exécutif les 29, 30 et 31 janvier. Les diverses recommandations des associations provinciales, les questions et les suggestions des déléguées en sont la preuve. Le Règlement VIII a été l'objet d'une étude critique et les changements suggérés furent étudiés avec soin. Il s'agit des comités nationaux et spéciaux qui sont d'une grande importance. Si les plans proposés pour le congrès biennal de 1954 sont mis à l'essai nous aurons l'occasion de voir fonctionner un comité sur le plan "horizontal." Le Comité du Programme espère préparer des discussions, des rapports, et des exhibits qui illustreront le fonctionnement des six comités.

Banff

La Chambre de Commerce de l'Alberta n'aurait pu envoyer de meilleures déléguées à l'assemblée de l'A.I.C. que Mlle Frances Ferguson et Mme Clara Van Dusen. L'enthousiasme de ces ambassadeurs de l'ouest est communicatif. Nous sommes attendues dans l'Alberta et les plans vont bon train pour nous faire admirer les attractions du parc national et nous faire jouir de tout ce que cette province peut nous offrir.

En plus du parc national, dont Banff et Jasper ont répandu la rénommée, savez-vous que l'Alberta possède un autre parc national? Celui de Waterton, dans le sud de la province, est consideré par les connaisseurs comme le joyau de la couronne. Il est petit mais ravissant, situé au coeur du pays des pâturages. Peut-être inscrirez-vous la visite de ce parc sur votre itinéraire?

Depuis quelques années nous nous sommes efforcées de developper notre programme de relations extérieures. Le dernier pas dans ce sens est la résolution adoptée par l'A.I.C. permettant aux "membres associées" de s'inscrire au congrès de Banff. Nous espérons en adoptant cette ligne de conduite que les membres des associations provinciales, ne faisant pas partie de l'A.I.C., membres intéressants et intéressés, auront l'occasion de développer une plus grande sympathie et compréhension envers l'association nationale. Nous savons toutes que bien souvent les femmes les plus actives de la paroisse sont d'anciennes infirmières. Elles sont demandées pour parler au "Local Council of Women," aux Cercles de Fermières, à l'Ecole des Parents, aux institutrices, etc. Elles seront bienvenue à Banff. Si elles, ou vous-même désirez voyager avec des amis en dehors de la profession, des parents et vos époux, tous, vous pourrez loger avec nous au Banff Springs Hotel. Pendant que vous assisterez aux assemblées pour vous remettre à la page, ils exploreront le pays et prépareront vos prochaines excursions.

Les Activites des Comites

Il est évident que les comités sont très actifs. Le Comité du Service Institutionnel est très occupé à la préparation d'un manuel d'orientation. Le Comité Exécutif a manifesté un intérêt marqué à l'élaboration du plan et a demandé que le manuel soit préparé de façon à pouvoir servir à toutes les spécialités du nursing.

ORIENTATION ET TENDANCES EN NURSING

Le Comité de la Politique en Matière d'Education a suggéré de former un comité chargé d'étudier les problèmes importants se rapportant au personnel infirmier des institutions psychiatriques tels que le programme d'étude pour les diverses catégories de personnel, les besoins de l'institution par rapport au personnel infirmier en vue d'assurer aux malades les soins que réclame leur état.

L'Etude sur les Attributions de l'Hospitaliere

Bien que le rapport sur les attributions de l'hospitalière (head nurse) ne soit pas encore prêt, M.-G.H. Josie a donné un rapport verbal au Comité Exécutif. Le Département des Recherches du Ministère de la Santé et du Bien-Etre est satisfait des résultats obtenus à date. Ils espèrent que les renseignements qu'ils ont accumulés pourront être utilisés pour établir des méthodes permettant d'étudier les activités des infirmières sans avoir à demander tous les mêmes détails qui ont servi à cette étude. Il suffira d'apporter des modifications.

Defense Civile

Le nombre des infirmières ayant suivi les cours de défense civile est imposant. Les découpures de journaux qui nous arrivent deux fois par semaine mentionnent toujours un nouveau groupe venant de terminer un cours. Nous espérons que ces infirmières continueront à suivre les cours qui seront donnés dans leur localité. Votre association provinciale ou le quartier général de la D.C. de votre ville sont toujours à votre disposition pour vous renseigner sur le prochain cours.

Le College Royal des Infirmieres

Une lettre récente du Collège Royal des Infirmières contenant un rapport des infirmières institutrices sur leur condition de travail. Bien qu'il ait eu quelques remarques sur leurs conditions de vie et sur les salaires, la partie la plus importante du rapport porte sur le manque d'appréciation des institutrices: "Tant que les autorités hospitalières considéreront les institutrices comme des bourreuses de crânes, en vue des examens ou encore, à l'occasion, des personnes propres à donner un enseignement officieux à des bénévoles, tant que le comité régional de la formation des infirmières déterminera ce que les institutrices doivent enseigner aux étudiantes pour que ces dernières soient en mesure de soigner les malades, au lieu de considérer ce que l'institutrice est en mesure d'offrir pour la formation de l'étudiante, les institutrices déserteront les rangs de l'enseignement."

Le rôle de l'institutrice comme éducatrice des élèves infirmières doit être reconnu. Ce manque de reconnaissance est le cause principale du départ des institutrices dans les écoles d'infirmières. Le point de vue des institutrices est intéressant — en effet, leur donnons-nous toute la considération à laquelle elles ont droit? Nous rendons-nous compte de leur besoin du temps qu'elles doivent donner à la préparation et à l'enseignement? Peuvent-elles réellement être des éducatrices si elles doivent être des bourreuses de crânes en vue des examens?

Colloque pour les Institutrices

L'école d'infirmière de l'Université de McMaster organise un cercle d'étude du 26 au 30 mai sur le sujet suivant — "Comment aider les étudiantes à appliquer dans le nursing leurs connaissances scientifiques." Mlle Laverne Thompson, R.N., M.A., du Teachers College, Columbia University, dirigera le cercle d'étude. Elle est l'auteur d'un livre sur la bactériologie. Ce cours s'annonce comme très intéressant; l'on insiste tant sur l'intégration de la science dans les soins aux malades.

Un Bourse d'Etude

Un bourse d'étude est offerte par le British Commonwealth and Empire Nurses War Memorial Fund aux infirmières canadiennes. L'an dernier la bénéficiaire de la bourse devait être de l'ouest. Cette année la bourse est offerte à une infirmière *de langue française ou du moins à une infirmière d'une province d'expression française.* Les personnes intéressées peuvent s'adresser au Secrétariat de l'A.I.C. pour plus de renseignements.

Le Nursing et la Rehabilitation

L'idée de plus en plus répandue que l'on soigne une personne malade et non une maladie a donné l'idée à un groupe d'institutrices d'organiser une démonstration sur la réhabilitation. Les soins donnés aux malades doivent comprendre la prévention des difformités, des contractions musculaires par le bon maintien, la bonne position du corps

et des membres, en chirurgie, en médecine et en orthopédie. Les activités quotidiennes de la vie peuvent être enseignées progressivement aux malades handicapés afin qu'ils soient aussi indépendantes que possible physiquement et mentalement.

Dès qu'un malade entre à l'hôpital le but de chacun et de tous doit être: Que pouvons-nous faire pour que ce malade retourne chez-lui comme un membre utile à la société?

Cet aspect de la réhabilitation devrait revenir plus souvent dans le programme d'étude puisque les soins donnés par l'infirmière sont un des facteurs importants de la réhabilitation.

Cours Post-Scolaire

L'Université de Toronto a organisé pour les infirmières un cours de trois jours sur "Les besoins de l'étudiante des écoles primaires, élémentaires et supérieures en matière de santé."

Une équipe, composée de l'infirmière, du médecin, du psychiatre, du psychologue, de l'assistante sociale de l'institution, des parents et de l'élève même, traita du sujet.

Book Reviews

Public Health Education: Its Tools and Procedures, by H. E. Kleinschmidt, M.D., and Savel Zimand. 302 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1953. Price $4.50.

Reviewed by Ann Peverley, Assistant Professor in Public Health Nursing, McGill School for Graduate Nurses, Montreal.

This book should prove to be of interest and value to all health workers, regardless of their specialty. It presents views which are based upon actual experience and study of health education activities in various parts of the United States. Fundamental principles are stated simply and clearly. The authors discuss in a very practical way the tools of communication. The reader will find good illustrations and helpful suggestions. The chapter dealing with Reporting to the Community is of special interest to the executive.

The reader gains an increased appreciation of the growth and development of public health education. Types of health education programs are vividly described. Interesting examples are given, illustrating general methods of training on the job as well as assignment of activities to volunteers. Educational qualifications and functions of the health education specialist are clearly set forth.

Appendix I includes particular reference to isotype in visual education. Appendix II suggests useful books and pamphlets, and Appendix III provides sources of material and information on health education.

This book should assist all health workers in utilizing scientific knowledge for the improvement of the health of all people in the community.

The Medical Inspection of School Children, by Edgar Henry Wilkins, M.B. 224 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1952. Price $3.00.

Reviewed by Nancy Lee, Public Health Nurse, Nelson, B.C.

Dr. Wilkins died in 1946 leaving the manuscript of this book incomplete. It has been compiled by an editorial committee appointed by the School Health Service Group of the Society of Medical Officers of Health of Great Britain. I do not think that the reader will find that this has caused any deviation from the purpose of the book as an authoritative manual on its subject.

The author does exactly what the title of the book indicates. He describes in detail the necessary steps in an effectual and thorough examination of the school child. He looks upon the school medical inspection as "the periodical health audit of the whole child." The "whole child" includes the child himself, his environment, and his response to that environment.

Dr. Wilkins was intensely conscious of the child's environment. He states that health education must go hand in hand with the housing program and a better standard of living. He devotes a whole chapter to the sociological background. This book is written for the medical profession,

both for those in full-time public health positions and the part-time school medical inspector. Inasmuch, however, as he describes, chapter by chapter, the norm to be expected and then discusses the common deviations and their significance, this book should be of great value to the public health nurse in her school program.

Hygiene, Infectious Diseases and Dietetics, by Dennis H. Geffen, M.D., D.P.H., and Susan Tracy, D.P.H. 276 pages. Longmans, Green & Co., 215 Victoria St., Toronto 1. 1952. Price $1.90.

Reviewed by Mrs. Lillian Aldous, Clinical Supervisor, General Hospital, Regina, Sask.

This book would be a credit to any library section on infectious diseases.

The material has been presented in an interesting and explicit style. The portion on hygiene would be especially helpful for the nurse doing home nursing in remote areas as it gives clear instructions for the control of the spread of infectious diseases and the essential principles for a preventive medicine program. The subject matter on infectious diseases has been introduced by a general discussion on the defensive mechanism of the body. Excellent principles for the nursing care in each of the specific diseases have been presented. The portion of the text discussing dietetics would be most beneficial from the preventive medicine aspect as well as for a reference in the treatment of the diseases.

Teaching in Schools of Nursing, by Alice M. Jackson, M.A., and Katharine F. Armstrong, D.N., S.R.N. 263 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 2nd Ed. 1952. Price $3.00.

Reviewed by Ingrid Penman, Senior Instructor, School of Nursing, St. Joseph's Hospital, Sudbury, Ont.

This text, primarily written for the sister tutors in British schools of nursing, contains sound information on the principles and practice of teaching that may be applied, for more effective teaching, by any instructor in schools of nursing.

In the introduction to the first edition Sir Cysil L. Burt, professor of psychology, University College, London, England, pays tribute to the co-authors for preparing this concise text on good psychological and practical principles. He states that the purpose of this book is to supplement the course of lectures in the principles and practice of teaching given to sister tutors and which fills a definite need for those engaged in British schools of nursing.

The text is divided into two parts with the purpose of each given. In each chapter essential points are discussed and briefly summarized. At the end of the text a comprehensive outline of the block system, as drawn up by the sister tutor committee, is outlined as well as a selected bibliography for the purpose of selecting a professional library. This is followed by an index.

Part I written by Miss Jackson gives the theoretical portion of this book. The first chapters discuss the importance of a tutor being well prepared not only academically but also as a person. She states "there is nothing so vitalizing to personality as the effect upon it of other personalities . . . our echoes roll from soul to soul. The sister tutor must always be aware of her own shortcomings and do all in her power to cultivate a positive attitude of the student toward life while forming their character." This first part also includes a chapter on the "mental make-up and development" of the young nurse in regard to her fears on or off duty. The author appeals to all instructors to try to have the student respond to a "positive love of right in their work rather than the negative fear of the consequences of wrong-doing." The following chapters of Part I are then devoted to the principles of good teaching which are based on sound psychological principles. The young instructor would find these concise informative chapters helpful on such topics as "interest and attention," "progress in learning" to name only a few.

Part II deals with the curriculum of the schools of nursing in England which, though interesting, is different from ours and of limited value to Canadian schools. The educational standards of those entering training are discussed at length with emphasis on more knowledge of science. In this chapter the preliminary training school, the block system, and the study day system of training, in which the student leaves the ward for the classroom for one day each week only during certain periods of their training, are reviewed. The value of ward teaching

is emphasized and one whole chapter is devoted to the head nurse as a teacher. Excellent points in their preparation of lectures and classes, with examples, are made. The sections on illustrations, discussion, and note-taking are of value as they, too, are clearly and concisely discussed with good examples given.

While the book is interesting, its use as a reference in Canadian schools is limited outside of the principles that have been laid down for better methods of nursing.

Nursing Care of Communicable Diseases —Prophylactic Technics for the Prevention and Control of Disease, by Mary Elizabeth Pillsbury and Elizabeth Johanna Sachs. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25, 7th Ed. 1952. Price $4.50.

Reviewed by Marjorie T. Brown, Clinical Instructor, St. Paul's School of Nursing, Vancouver.

This textbook provides comprehensive, yet detailed material concerning the nursing care of communicable diseases, divided into four sections. The first section deals with the scientific bases and techniques for the control of communicable disease spread and includes a chapter devoted to general chemotherapy and antibiotic therapy. Included, too, is an excellent chapter dealing with the nursing techniques in the hospital, amply supplemented with illustrations. Within this particular chapter comparative prophylactic techniques for the hospital and the home are outlined.

In the second section the author recognizes the lack of a satisfactory method of classification of communicable diseases by causal organisms, the method of entrance, or clinical symptoms and has considered the diseases alphabetically, with a few exceptions, where comparative studies prove helpful. Throughout this section special attention is given to the nursing aspect of communicable diseases, with special nursing points in the care and contact of the patient.

Section Three contains an historical review of the hospital and public health care of communicable diseases, which includes an interesting account of the role of the nurse and her progress in the field of prevention and care of communicable diseases.

The fourth and final section includes supplemental material, including disinfection procedures, general references, and a list of audio and visual aids, as well as a program of clinical instruction in communicable disease nursing, and a group of situation questions which are planned to serve as a study guide for student nurses.

Throughout the text the role of the nurse as a teacher of health is emphasized and encouraged.

The nurse who is concerned with planning a program of instruction in nursing care of communicable diseases will find this publication of great value—either as a text for the individual student nurse, or as an additional reference in the library.

Measuring Your Public Relations, by Herman D. Stein. 48 pages. National Publicity Council, 257 Fourth Ave., New York City 10. 1952. Price $1.25 (in U.S.A.).

Comparative newcomers in the field of public relations, hospitals, public health organizations, and even our national and provincial associations will find much helpful information in this pamphlet. Where it is possible to afford the services of an expert there is less need for the executive officers themselves to undertake the planning for this type of program. However, since relatively few of the above groups are able to afford the expense of a highly qualified public relations officer there is a definite need for members on the staff to know some of the fundamentals before they launch a program of public relations.

This is particularly true if a sampling of public opinion is desired. Such questions are suggested as: "What publics are important to you?" "Why are they important?" "What do you wish to communicate to each?" The answers found here will help the inexperienced public relations chairman.

The federal Minister of Labor has announced that an Order in Council had been approved which called for the insertion, after January 1, 1953, in all government contracts of a clause forbidding discrimination in employment on grounds of race, national origin, color or religion.

THE PROVINCE OF MANITOBA REQUIRES

A GRADUATE NURSE

for the Hospital for Mental Diseases at Selkirk, Man.

Duties: Supervision and direction of operating room and central supply room.

Education: Applicants must be Registered Nurses preferably with some psychiatric training.

Salary: $2,640.00 - $3,000.00 per annum, less $300.00 for full maintenance.

The above position offers regular increases, liberal sick leave with pay, 4 weeks' vacation with pay annually and pension privileges.

Apply stating qualifications and experience to:

MANITOBA CIVIL SERVICE COMMISSION

247 Legislative Building Winnipeg, Manitoba

In the Good Old Days

(*The Canadian Nurse*—APRIL 1913)

"OCCUPATIONAL STATISTICS show that, of the thousands of women practising nursing, only about 10 per cent are hospital trained . . . One correspondence school reports 12,000 graduates in 10 years whereas one of the largest hospitals has had only a few over 600 graduates in 20 years. Unfortunately, there is no law that debars anyone from calling herself a nurse and practising as such."

* * *

"Is it foolish, can it be priggish, to speak of *ideals* at this day and age? Never, when speaking to nurses. What is every true nurse's definition of nursing? About this—the *best* care I can give to *all* who *need* me. This does not mean to all who *call* me. There is a difference between those who *expect* and those who *should get.*

"*All* means that no nurse should deliberately make up her mind to shut out any class of people or kind of sickness from her plans for nursing. Should nurses plan, for example, on 'not taking' maternity cases or fever cases? The answer is *no!*"

* * *

"During the last few years there has been a gradual increase in the nurses' salaries, which is in accordance with our modern methods. To pay a salary to our nurses, while they are working, sufficient to enable them to put by for the proverbial rainy day, is much better than any system of pensions."

Ontario

THE FOLLOWING are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Ruby Forward* (Sherbrooke Hosp., Que.; McGill University public health nursing course; University of Toronto advanced course in mental hygiene—administration and supervision) and *Edna* (*Stoddart*) *Dent* (B.Sc.N., University of Western Ontario) as supervisor and staff nurse respectively, Kent County health unit;

A WAIVER IN ONTARIO UNDER THE NURSES' REGISTRATION ACT — 1951

Notice is hereby given that the regulations under the Nurses' Registration Act, 1951 (Ontario) include a waiver which reads as follows:

"The Board shall register without examination any person

(a) who

(i) graduated from a school of nursing, and

(ii) was eligible for registration as a registered nurse under any Act of this Legislature before the year 1926; and

(b) who has not registered as a registered nurse where that person

(c) applies for registration before the 31st of December, 1953, and

(d) pays the registration fee prescribed by sub-Regulation 2 of Regulation 12."

For interpretation of eligibility and for individual application write to the **Registrar, Registered Nurses' Association of Ontario, 515 Jarvis St., Toronto 5, Ontario,** stating name and location of School of Nursing, and year of graduation.

Noella and *Jeannette Bellemare* (St. Joseph's Hosp., Three Rivers, Que. and U. of Montreal p.h.n. course) to Prescott and Russell health unit; *Marycke Diephuis* (Royal Melbourne Hosp., Australia, and certificate course, Utrecht, Holland) to Kitchener board of health; *Adelin (Schweitzer) Graham* (St. Joseph's Hosp., London, and U.W.O. cert. course) to Middlesex Co. school health service.

Frances (Orr) Ham (Hosp. for Sick Children, Toronto, and U. of Toronto general course) to Northumberland and Durham health unit; *Eleanor (Jamieson) Hurd* (B.Sc., public health, U. of Alberta; advanced course in admin. and supervision in p.h.n., McGill U.; M.P.H., U. of Michigan) to Simcoe Co. health unit; *Anna Jones* (Belleville Gen. Hosp. and U. of T. gen. course) to East York-Leaside health unit; *Virginia (Marshall) Pollard* (B.Sc.N., McMaster U.) to Peel Co. health unit; *Myra Walker* (Greater Niagara Gen. Hosp., Niagara Falls, and U. of T. gen. course) and *Marguerite (Northup) Watts* (Mountainside Hosp., Montclair, N.J., and McGill U. p.h.n. course) to Welland and district health unit; *Joyce Webster* (Winnipeg Gen. Hosp. and McGill U. p.h.n. course) to Sault Ste. Marie board of health.

Resignations: *Mrs. May Stewart* as senior public health nurse, Sudbury board of health; *Beulah (Scott) Hammond* from Peel Co. health unit; *Burma Morlock* and *Jean McArthur* from York Township board of health; *Margarethe Petersen* and *Margaret Shoebottom* from Huron Co. health unit; *Ellen (Prowley) Turpin* from Scarborough board of health to go to Springfield, Mass.

Victorian Order of Nurses

THE FOLLOWING are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Burnaby, B.C.: *Margaret Culley* (Grace Hosp., Windsor, Ont.). Calgary: *Vera Lucke* (Saskatoon City Hosp.). Halifax: *Ann Schoenberger* (Winnipeg Gen. Hosp.). Moncton: *Mrs. Barbara Beggs* (Toronto Gen. Hosp.). North Vancouver: *Mary E. Harden* (Winnipeg Gen. Hosp.). Sackville, N.B.: *Mrs. Kathleen Tower* (Montreal Gen. Hosp.). Saint John, N.B.: *Janet Crammond* (Saint John Gen. Hosp.) and *Anne Marie Pierce* (St. Joseph's Hosp., Saint John). Sarnia, Ont.: *Betty Ann McLaren* (Gen. Hosp., Galt). Toronto: *Mary Jackson* (Toronto Gen. Hosp.).

Reappointments—Cornerbrook, Nfld.

(new branch): *Stella Warwick.* Port Colborne, Ont.: *Mrs. Betty Gallinger.*

Resignations—Halifax: *Mrs. Carmen MacDonald.* Moncton: *Mrs. Anna Allain.* Saint John, N.B.: *Erie Lloyd.* Toronto: *Marjorie Scott, Mmes Georgina Hughes, Virginia Pollard.* Victoria: *Jean Allen.* Windsor, Ont.: *Elizabeth Martin.*

Nursing Sisters' Association

The annual meeting and dinner of the *Hamilton Unit* was held in February at the R.C.A.F. Officers Mess when A. Welstead, past president, and Mrs. M. Hoffman, newly elected president, welcomed the guests and members. The guest speaker was Dr. W. Deadman who gave an interesting talk on "The Evolution of a Canadian." He was thanked by D. Marshall.

The reorganized *Windsor Unit* had a very successful year, holding meetings monthly in the Garrison Officers' Mess. Twenty-eight members attended the Armistice Day dinner and a wreath was placed at the Cenotaph by the president.

The following officers will serve for the coming months: President, Irene Courtney; vice-president, M. Parteschuk; secretary, P. Black; treasurer, M. Williams. Committee conveners: Social, A. Andrews; program, J. McDougall; publicity, E. McIntyre. Advisers, Mmes A. Wallbank, J. Kent.

News Notes

ALBERTA

CALGARY

F. Tennant, president, was in the chair at a meeting of District 3 when 27 members were present. F. Ferguson reported on the C.N.A. Executive Committee meeting held in Montreal. Members were urged to keep up to date on information appearing in the *Journal* and in the Alberta *News Letter* where reports will be enlarged upon and further details given regarding the 1954 C.N.A. biennial convention. Miss Deane-Freeman reported on the Civil Defence organization demonstration which she attended in Edmonton.

E. Shaw accepted the nomination as

WHEN YOU TRAVEL!
"HYOTHEN"
Prevents or relieves
CAR- SEA- PLANE
or
TRAIN SICKNESS
Now really enjoy travelling . . . by taking Hyothen to protect against or relieve upset or dizziness.
Proven effective by clinical trial against all forms of motion sickness, Hyothen and children's Hyothen are available at drugstores. Both strengths come in handy boxes of 12 and larger economy sizes.
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I. ***A basic professional curriculum leading to the degree, Bachelor of Science in Nursing:*** A five-year course for students with Junior Matriculation; those with an appropriate Senior Matriculation can complete requirements in four years.

II. ***Curricula for Graduate Nurses:***

1. Leading to the degree, Bachelor of Science in Nursing, with a major in:
   - (a) Clinical Supervision.
   - (b) Public Health Nursing.
   - (c) Nursing Education.
2. One-year Courses leading to a Certificate in:
   - (a) Clinical Supervision, to be focussed on one of the following:
     - (1) Medical-Surgical Nursing,
     - (2) Obstetric Nursing, or
     - (3) Pediatric Nursing.
   - (b) Public Health Nursing.

For further information write to **Director, School of Nursing, University of British Columbia, Vancouver 8, B.C.**

chairman of the Public Health Nursing Committee. R. Russell will serve as chairman of the Private Duty Section and Sr. Trottier as councillor.

The following motion was carried: "That the fee for associate members be increased to $3.00 so that $2.00 could be paid to the C.N.A. in order that associate members could become affiliated members of the C.N.A."

Mr. H. P. Capozzi was the guest speaker, his subject "Travelling in Southern Europe."

General Hospital

At a meeting of the alumnae association a committee was elected to purchase any necessary articles that would add to the comfort of the nurses' residence. Already the residence has received an electric sewing machine and two electric irons.

The following officers will serve for 1953: President, Mrs. T. Yearwood; vice-presidents, M. Podwysocki, D. J. Munn, Mrs. S. Russell, I. Boris; recording and corresponding secretaries, R. Pollock and Mrs. J. J. Porter; treasurer and membership, Mrs. W. T. Brigden. The following will also serve in various capacities: P. Boake, B. Johnstone, Mmes B. Katz (press convener), J. Turner, C. W. Boyd, D. G. McInnes, C. F. Parks, D. Thompson, C. D. MacKenzie.

CLARESHOLM

Eight members were present at a meeting of the Claresholm Branch of Chinook Chapter. Ada Sandell, a nurse serving in Korea, sent a letter of thanks for a parcel of white stockings. The next gift will contain thermometers as well as stockings.

The following officers will serve during the coming months: President, Mrs. A. Purcell; vice-president, Mrs. J. Watkins; secretary, Mrs. I. Gray; treasurer, D. Hill.

EDMONTON

Royal Alexandra Hospital

Mrs. J. Boutillier was elected president of the alumnae association at a regular meeting. I. Johnson will serve as honorary president. Assisting the president are the following: Vice-presidents, Mrs. R. English, J. Hamilton; recording and corresponding secretaries, I. Fairley, Mrs. A. Layetzke; treasurer, M. Causey. Councillors, V. Chapman, Mmes G. Dunaway, T. Payne. In charge of committees, E. Oatway, M. Edgar, M. Griffith, Mmes O. B. Cameron, W. McKeever, Gardiner. Representatives to various organizations include: Mmes M. McCallum, L. Barrie, S. Boucher, D. Ferrier. The press conveners are Mmes A. McPhee and N. Richardson.

JASPER

The Edith Cavell Chapter held a meeting in January at the home of Mrs. Pohlman when Mrs. J. Anderson presided. It was agreed to continue the preschool clinics and inoculations. A social evening followed when the hostess was assisted in serving refreshments by Mmes D. Bonner and P. Brodie.

A later meeting, held at the home of

Mrs. C. Stewart, was attended by nine members. A report was given on the well baby clinic, stating that Dr. O'Hagan suggested that all the doctors take part in turn at each clinic for examination and inoculation of preschool-age children. Mrs. Stewart offered to keep the registers and files for the clinic for this year.

The following officers were elected: President, Mrs. R. Recknagle; vice-president, Mrs. Bonner; secretary, Mrs. T. Bruce; treasurer, Mrs. Harmon.

Westlock

A Christmas party with all the trimmings was in order one evening in January at the home of Mrs. F. Roberts when the Westlock Chapter celebrated its first birthday. Twenty-four nurses were present. Guests were Mrs. C. Van Dusen, A.A.R.N. registrar; and E. Bietsch, superintendent of nurses, Edmonton General Hospital. The president, Mrs. Roberts, congratulated the members on the excellent attendance during the year and welcomed two new members. The secretary, Mrs. M. Gilchrist, summarized the work of the chapter, the main items being two successful blood donor clinics, the sending of Christmas parcels to students from Westlock enrolled in schools of nursing, and a course in civil defence. Miss Bietsch gave a report on the Structure Study, urging the members to study it carefully. Mrs. Van Dusen answered all questions asked by the members and congratulated them on the amount of work done in such a short time.

In the accompanying photo may be seen—*left to right*—Mmes F. Steeninger, M. Gilchrist, F. Roberts, Misses E. Bietsch, H. Heffernan. *Under tree* — Mmes Van Dusen, L. Kickham.

BRITISH COLUMBIA

Vancouver Island District

Mrs. E. W. R. Best, president of Nanaimo Chapter, welcomed nearly 90 nurses to the annual meeting of the district held on February 6. The guest speaker was Lyle Creelman, introduced by D. Priestly. Her address on "Nursing Around the World,"

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with slides on India, Burma, Ceylon, Switzerland, Finland, and Scotland, was the highlight of the evening.

Mrs. E. MacPherson of Cowichan Chapter, as chairman of the nominating committee, presided at the election of officers: President, Mrs. V. Tams, Plateau; vice-president, Mrs. J. Field, Nanaimo; secretary-treasurer, Mrs. O. Bell, Plateau. Councillors: Mrs. R. Bosward, Victoria; D. Priestly, Nanaimo.

Kamloops-Okanagan District

The October semi-annual meeting of Kamloops-Okanagan District was held in Kamloops when dinner was served at the Plaza Hotel and vocal numbers by V. Denman were greatly enjoyed. The guest speaker was Alice Wright, R.N.A.B.C. executive secretary, who gave an informative talk on "Registration—Its Purpose and Requirement" with special reference to reciprocal registration.

Following the regular business and reports the following officers were elected: President, Mrs. P. Trueman, Kelowna; vice-presidents, J. Sutcliffe, Vernon, and I. Stewart, West Summerland; secretary-treasurer, H. Empey, Kelowna. Also serving on the executive are: V. Denman, A. Beattie, Mmes H. B. Crothers, A. Breckenridge.

Chilliwack

The annual meeting of Chilliwack Chapter brought reports of an active year and the return of several former executive members to office. Renamed as president was K. Crowley with Mrs. H. Edmeston as vice-president.

Other officers elected were: Secretary, M. McCartney; treasurer, E. Gibbons. Committees: Program, Mmes P. Penner, H. Hudson; visiting, Mrs. H. Bersen; membership, Mmes F. Storey, D. Abbot; ways and means, Mrs. E. Firby; press and publication, Mrs. D. Christie; *The Canadian Nurse* representative is Mrs. G. Mathews.

Fund-raising activities included a June tea and a rummage sale. Through the Save the Children Fund a child was "adopted" and the Enid Chadsey Bursary was awarded to S. Holmes who is now enrolled at the Vancouver General Hospital School of Nursing. In cooperation with the Red Cross, home nursing classes were conducted by Mrs. F. Barwell with the chapter supplying instructors. Other community enterprises included contributions to the arena; donations to the C.N.I.B., and a float in the Cherry Carnival. Representatives to the Local Council of Women, Film Council, and CARS also report regularly. Mrs. F. Barwell and K. Crowley represented the chapter at the R.N.A.B.C. convention in Victoria.

During Nurses' Week in June, a member of the hospital staff spoke to pupils at the high school on the nursing profession and a local store window was dressed to bring attention to this special week.

Arrangements were made for those wishing to attend the annual district meeting in Langley. The nurses voted to give $25 to the Overseas Flood Relief Fund and $10 to the Bread for Greece Fund. Plans are being

made for the chapter to visit the Crease Clinic.

KELOWNA

Twenty-two members were present at the annual meeting of Kelowna Chapter, held at the home of Mrs. P. Trueman. H. Empey will continue as president for another year. Additional officers include: Vice-president, A. Beattie; secretary, M. Koop; treasurer, Mrs. C. Chambers. The following are also serving in various capacities: Mmes G. McClelland, R. Cresswell, A. Breckenridge, J. Hough, M. Werts, P. Trueman, L. Paige, H. Bunce, Miss W. Grigg.

A successful dance was held last December, netting over $100. The chapter paid $300 toward the cost of purchasing chrome chart racks for the nurses' stations in the General Hospital. Four chapter members have volunteered to give Red Cross home nursing classes and seven others have offered to be on call for duty at the Civil Defence emergency posts.

NELSON

At the annual meeting of Nelson Chapter a very busy year was reported. Members took part in Civil Defence and A.B.C. Warfare lectures given by Nancy Lee, P.H.N. A refresher course in advanced first aid was well attended by both active and inactive members. Several members assisted in the recovery room at the annual Red Cross Blood Donor Clinic. Members also had charge of the registration of a thousand persons who took advantage of the free miniature chest x-rays at the Fall Fair. Several married members gave invaluable assistance to the local hospital staff during the fall polio emergency. Two $100 bursaries were awarded to Nelson girls entering schools of nursing.

The Loan Cupboard Service, operated by the Red Cross and the public health nurses, has had a very successful year. The Gatch beds, wheel chairs, etc., have been in constant demand. The loan cupboard now has its articles stored in the Isolation Building at K.L.G.H., thereby making it more convenient for patients leaving hospital to procure anything needed during their convalescence. The Nelson Kinette Club has in the past two years presented the cupboard with a wheel chair and a Gatch bed with mattress.

The annual district and provincial meetings were well attended as well as having a district representative in the person of F. McLean at the C.N.A. biennial convention in Quebec.

The following officers will serve for 1953: Honorary president, E. Swan; president, F. McLean; vice-president, Mrs. W. Van Maarion; secretary-treasurer, Mrs. J. McDougall. Committees: Entertainment, Mmes N. Buckley, Van Maarion, A. Pagain; ways and means, R. Hornett, Mrs. D. Hunter. Mrs. R. Barber is representative to *The Canadian Nurse*.

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ROSSLAND

M. Cressman, public health nurse, was elected president of Rossland Chapter by acclamation at a meeting held in January. Mrs. W. K. Scatchard is vice-president, L. Cooper, secretary, and the treasurer is Mrs. R. A. Williamson. The following members will also serve in various capacities: Mmes J. E. Barrett, A. M. Martin, J. R. Osborne, W. C. Stevens, R. Thompson, A. W. Irish, and A. H. Wood.

The retiring president, Mrs. W. K. Scatchard, reported that a successful year had been enjoyed and expressed her thanks to the officers and members for their splendid cooperation and to Mr. Trevor-Jones for his assistance in auditing the books of the chapter. Refreshments were served by Mmes Topliff and Scatchard.

MANITOBA

WINNIPEG

Misericordia Hospital

The alumnae association's Spring Tea was held in February, Mrs. M. Martin acting as convener, assisted by Mmes E. McLaren, E. Martin, and V. McCullough. Mrs. D. Cutts was in charge of the home-cooking table, Mrs. R. Natsuk the handicraft booth, and Mary Jane Ego handled the raffle. The guests were welcomed by Margaret Wilson, alumnae president, and Mrs. Martin.

NEW BRUNSWICK

FREDERICTON

At the February meeting of Fredericton Chapter, held at Victoria Public Hospital, Isabel Lane was guest speaker, telling of her work as adviser to the 14 schools of nursing in the province. Miss Lane's discussion was both instructive and enlightening, showing how much the provincial association means to the local nurses and to every nurse in the province's schools of nursing.

The president, Mrs. M. M. Scott, welcomed the new registrar, Mrs. A. Scammell, a V.P.H. graduate, and former executive member of the chapter, who took up her duties in January. The report of the public health nurses' committee was given by Mrs. D. Callan and that of the institutional nurses by A. Downing, a staff member of V.P.H. Mrs. R. Crewdson reported for the legislative committee and V. Burchell for the registry committee. The report of the Provincial Executive Council was given by K. MacLaggan.

At a special meeting of Fredericton Chapter held in February at V.P.H., Catherine Perkins, assistant editor and field representative of *The Canadian Nurse*, addressed the nurses, taking as her subject "Orientation," treating it from the viewpoint of the staff nurse and the private duty nurse. The open discussion that followed was lively and informal. The chapter president,

M. M. Scott, introduced Miss Perkins and she was further made welcome by the chapter's convener for the *Journal*, A. Miller.

The reports of the various committees were heard and a special request was made to the nurses to assist at the blood donor clinics. Mrs. A. VanWart is the chapter's representative at these clinics.

A reception followed the meeting when P. Nason, on behalf of the chapter, thanked Miss Perkins for her visit and address and presented her with a nosegay. Refreshments were served under the convenership of Mmes L. Menzies and F. Rankine, assisted by M. Lee, Mmes F. Gibson, R. Crewdson, E. Kelly, and G. Perley.

Moncton

A dinner party was held by the members of Moncton Chapter when 29 nurses were present. A minute of silence was observed in memory of the late Mrs. L. D. Wadman who had been a chapter member for many years. Grace was recited by Mrs. M. J. Perry. Mrs. N. Smith, president, was in the chair for the business session. Reports were given by committee chairmen. A sing-song was led by S. Stevens and much enjoyed.

Hotel Dieu

Sr. M. Louise, director of nurses, attended a meeting of the alumnae association when 20 members were present. The senior students of the school of nursing were invited guests.

The following officers were elected: President, A. Albert; vice-president, B. Melanson; secretary, N. LeBlanc; treasurer, S. Robichaud.

At the close of the meeting lunch and entertainment were provided by the student nurses.

Saint John

Sponsored by the Institutional Nursing Committee of the N.B.A.R.N., a conference of instructors of the 14 schools of nursing in the province took place at the General Hospital, with B. Selfridge presiding. The conference dealt with the change in examinations for registration now being made. A qualifying exam, at the end of the first year in training, as well as one at the end of the training period, is now required.

Catherine Perkins, assistant editor and field representative for *The Canadian Nurse*, was guest speaker at a meeting of Saint John Chapter when L. Smith, the president, was in the chair. Miss Perkins stressed the responsibility of nurses to their profession. Invited to the meeting were the instructors of schools of nursing in the province and the senior student nurses from the General and St. Joseph's hospitals.

Further plans were made for the Easter Dance, the proceeds to go towards the nurses' registry.

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General Hospital

B. Selfridge was elected president of the alumnae association at the annual meeting presided over by A. Hanscome, second vice-president. The senior class of the school for nurses was invited to attend the April meeting when the members would pack food parcels for England. It was reported that the material for the history of the school for nurses has been coming in satisfactorily and it was hoped to have it ready for publication at the end of the year.

Other officers elected were: Honorary president, E. J. Mitchell; vice-presidents, Mrs. W. McKinnon, S. Wetmore; secretary, M. Moore assisted by A. Hanscome; treasurer, Mrs. S. Rankin assisted by Mrs. L. Dunlop. Additional executive, A. K. Donahue, P. Harrity, J. Johnson, Mmes M. O'Neal, L. Dunlop.

St. Joseph's Hospital

A class of 17 preliminary student nurses received their caps in a ceremony held recently when the Rev. Dr. Joseph M. Gallagher, chancellor of the diocese of Saint John and chaplain of the hospital, presided and in a brief address told the group that "nursing was a means of acquiring knowledge and discipline and of doing great good for others." Sr. M. Bernard, principal of St. Vincent's Girls High School, urged the nurses to keep their ideals high and be loyal to one another and to those who teach them. Sr. M. Veronica, hospital superior, welcomed the new students.

The Nightingale Lamps were used in the ceremony. Caps were presented by Sr. Helen Marie, director of nurses, assisted by Sr. M. Rosarie, educational director, and W. Ruland, nursing arts instructor. M. McDermott contributed vocal selections, accompanied by A. Corkery.

Tuberculosis Hospital

Agnes Griffin, a member of the nursing staff, celebrated the 25th anniversary of her appointment to the staff recently. In honor of the event, M. Myers, superintendent of nurses, and the nursing staff entertained at bridge in the nurses' residence. Dr. Irene Allen presided over the coffee cups, assisted by members of the nursing staff. Miss Griffin was presented with a travelling bag by Dr. R. J. Collins, hospital superintendent, who expressed the good wishes of the staff.

Mrs. E. Fraidey, staff member for several years, was given a farewell party when Dr. Collins presented her with a table lamp on behalf of the staff. Mrs. Collins presided at the tea table when refreshments were served. A. Baker has resigned to be married. Prior to her departure, she was entertained at a tea by the nurses and presented with an electric kettle and a gift of china.

N. Wimer and J. Bradley have joined the

staff of the children's wing. V. Marr is on duty in the medical division. D. Barter has gone to the D.V.A. Hospital in West Saint John after four years of staff duty.

ONTARIO

District 1

Sarnia

Mrs. H. Griffiths of Sarnia was elected chairman of District 1 at the annual meeting held in February. More than 100 registered nurses from Kent, Elgin, Essex, and Middlesex counties were present. Martin Boundy, director of the London Police Boys' Band, was guest speaker during the evening sessions, which were preceded by a banquet. His subject was "Youth in Music" and he described in general terms the opportunities in music provided for young people of the city. His talk was followed by musical selections.

Mrs. F. Clazie of Windsor presented her report on private nursing, announcing a one-month refresher course for nurses who have been away from bedside nursing. This will be arranged by the Windsor Registry and instructors of nurses, to be given at Hotel Dieu, Windsor.

The following conveners read annual reports for their committees: Institutional nursing, P. Black; public health nursing, M. C. Smith; private nursing, Mrs. F. Clazie; industrial nursing, M. Sloan; membership, A. Graham; publications and *The Canadian Nurse*, M. Gray; finance, G. M. R. Erskine; nominations, I. Griffin; program, H. Griffiths; Kent Co. chapter, Mrs. A. Berry; Elgin Co. chapter, I. Poole; chairman's report, E. Horton.

Reading a report on a meeting of the R.N.A.O. Board of Directors, Miss Horton said: "The matter of nurses paying unemployment insurance is being taken to the C.N.A. with a request for action." She also pointed out that nurses who graduated from approved schools of nursing prior to 1926, and who did not register at that time, may still register without examination. She also stated that there are 7,342 nurses and 339 instructors prepared in the nursing aspects of A.B.C. warfare and noted that there are now about 11,000 nursing assistants in Ontario. Referring to the inadequacy of nursing personnel, Miss Horton said that a joint brief has been presented to the Minister of Education by the Ontario Hospital Association and the R.N.A.O., expressing the need for government financial assistance for the education of nurses at the rate of $400 per student.

The following will serve on the executive with Mrs. Griffiths for the coming months: Vice-chairmen, O. O'Neill, E. Holmes; secretary-treasurer, D. Hollister. Councillors, I. Poole, M. Smith, W. Hughes, Mmes M. Quinn, A. Berry, H. Rooney.

Members voted that Mrs. Griffiths and Miss Hollister attend the R.N.A.O. annual meeting as delegates.

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CHATHAM

Mrs. C. Salmon was re-elected president of the Community Nursing Registry at the recent annual meeting. It was announced that nurses' fees have been raised from $8.00 to $9.00 per day. Reports revealed that during 1952 the registry received 1,772 requests for graduate nurses but due to the shortage of help 1,400 requests went unfilled. Sixty-five requests were received for nursing assistants. Last May the registry, at the request of the Chatham Medical Association, undertook the job of looking after calls for city doctors.

Mrs. E. Cripps took over the duties of registrar when Mrs. M. Jackson resigned. Mrs. Jackson became registrar when the registry was organized in October, 1942.

The chairman, Mrs. Salmon, is to be assisted by vice-chairmen Mrs. M. Challis and M. Moore and secretary A. McKenzie. A. Head, registry committee chairman, is to be assisted by Sr. M. Marian, W. Fair, and D. Marini. The chairman of the credentials committee is D. Thomas, assisted by W. Mervin, Mmes I. Meloche and M. Mulhern. Mrs. M. Murray heads the educational committee with B. Sauer, M. Werry, Mrs. E. Murphy, and Dr. Seltzer assisting. The public relations committee includes chairman, Mrs. M. Jackson; Mrs. E. Lafferty, M. Case, and Dr. Samson. The personnel of the finance committee includes: Chairman, Mrs. I. Keenan; Miss M. Gilbert, Mmes H. Kennedy, P. Stacey, E. Beckett, J. L. Callaghan, and Blair McKinnon.

LONDON

Ontario Hospital

Members of the alumnae association staged their first Mother and Daughter Night in February when the guest speaker was Merle ("Ting") Tingley, *London Free Press* staff cartoonist. Introduced by R. Stephenson, "Ting" illustrated the development of a cartoon and accompanied his sketches by humorous commentary. He was thanked by B. Jones. The president, Mrs. M. Daiken, welcomed affiliate nurses as guests. Mrs. W. Soutar presided at the tea table in the reception room of the nurses' residence.

DISTRICT 2

ST. MARYS

The St. Marys Graduate Nurses' Association held a regular meeting at the home of Mrs. H. Newton. The new president, Mrs. W. Butters, was in the chair. A letter was read from Mr. L. P. Whaley, thanking the nurses for their gifts to the Memorial Hospital. The Home and School requested that the association support a health play to be put on by University of Western Ontario students. Dr. Martin Humphris, guest speaker, talked on "Heart Diseases," classifying the different types of heart impair-

ment and treatments and medicines now being used for each condition. Mrs. Simpson introduced Dr. Humphris who was thanked by Mrs. B. Pringle.

Lunch was served by L. Cade, E. Lancaster, and Mrs. R. Baird.

WOODSTOCK

Kathleen Erb recently left for Quito, Ecuador, where she will begin her second term as missionary nurse to the Ecuadorian Indians. A graduate of the General Hospital, Miss Erb attended the London Bible Institute and during the past months has been taking a specialized course at the Hospital for Sick Children, Toronto.

In Quito, Miss Erb lives at the mission radio station of HCJB high in the Andes Mountains. There she is in charge of the clinic where the Indians are given medical care.

During the earthquake disaster in Ecuador several years ago, Miss Erb and one of the mission doctors were honored by the government for being the first on the scene to give medical aid.

DISTRICT 3

OWEN SOUND

General and Marine Hospital

The annual meeting of the alumnae association was held in January with 15 members present. Mrs. Keeling was in the chair for the business portion of the meeting. Miss Showell gave a report on the showcase to be placed in the lobby of the hospital and a letter is being sent to each alumnae member, giving an outline of the case and articles required for it. Miss Cooke expressed appreciation to the retiring president, Mrs. Keeling, for her excellent leadership during the past year and Mrs. Keeling extended a welcome to the new president, Mrs. J. Dewar, who presided for the remainder of the meeting.

It was decided that the ways and means committee of the alumnae and nurses' registry would meet and pool ideas for the year, all combined projects in future to be on a 50-50 basis.

The following members will serve on the executive with Mrs. Dewar: Honorary presidents, E. Webster, W. Cooke; vice-president, A. Cook; secretary, H. Weeden; treasurer, A. Matches. Additional executive members are: R. Showell, E. Cook, L. Rice, D. Edmonstone, L. Gowan, D. Bartman, D. Hargraves, N. Rusk, S. McLay, J. Breen, Mmes D. Storey, D. McKerroll, Storey, D. Fleming, Keeling.

DISTRICT 5

TORONTO

W. Hendrikz was re-elected president of District 5 at the annual meeting held in January. Drawing attention to work being done by nurses from this area in profes-

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sional fields abroad, including India, Pakistan, and Formosa, she said that every member of the R.N.A.O. can make an international contribution by influencing others, by her interest, and by personal and professional development. The membership convener reported an increase of almost 700 in the district since 1951.

Among the donations reported by the bursary committee were: Toronto Rotary Club, $400; Rameses Mystic Shrine, $400; North Toronto Business and Professional Women, $50; Humber-Credit Valley Soroptimist Club, $150; Toronto East Medical Association, $25. Six hundred dollars were allocated from the district concert proceeds to enable eight student nurses to receive full bursaries. Five received bursary assistance and more applications are under review.

The following officers will assist Miss Hendrikz during the coming year: Vice-chairmen, M. J. Wilson, R. Watson; secretary-treasurer, Mrs. M. Chisholm. Councillors, M. A. Wickham, M. A. Agnew, D. E. Arnot, M. G. Kennedy, B. B. Grant.

Dr. Marcus Long, guest speaker, entitled his address "The Things That Matter."

Wellesley Hospital

In February an enjoyable tea was held in the nurses' residence in honor of the superintendent of nurses, E. K. Jones, who is celebrating her silver anniversary on the hospital staff. At this time Miss Jones was presented with numerous gifts, among them a sterling silver tea service from her nursing staff, alumnae and medical associates.

Women's College Hospital

The alumnae association presented corsages to 21 preliminary student nurses who received their caps in February. Instead of the alumnae holding their Spring Fireside Tea, the members are supporting the tea and draw sponsored by the student nurses. The first prize is a round-trip to New York, while the second prize is a fur neckpiece. The proceeds will go towards the W.C.H. Building Fund. A tea and home-baking sale to be held by the Central Registry of Graduate Nurses will also help to augment this fund.

M. Easton and M. Sharp are with the Etobicoke board of health, working with E. Hulse. J. Moore and M. Crossley are doing general duty in Kimberley, B.C.

District 8

Cornwall

Mrs. A. McIntosh was elected president of the Community Nursing Registry at the recent annual meeting. The following will also serve during the coming months: Vice-president, Mrs. T. Tobin; secretary, Mrs. V. Whaley; treasurer, Mrs. A. C. McInnis. Sr. St. George, M. Nephew, and E. Allen were named to the credentials committee; S. Everitt, educational convener; Mayor A. Horovitz, finance; Sr. Mooney, publicity;

Mrs. B. Moore, flowers; Mrs. B. McCourt, entertainment.

An interesting statistical report was given by the registrar, M. McWhinnie. A total of 4,720 calls were handled for nursing care in 1952, greatly exceeding those in 1951. Of the 575 cases for which nurses were needed, 445 received nursing care through the registry. A total of 4,775 calls were handled for the medical men in Cornwall who use the registry.

OTTAWA

E. Horsey, re-elected president, was in the chair at the annual meeting of the Community Nursing Registry. In presenting her report of the activities of the official Ottawa registry for graduate nurses, I. Johnston, chief registrar, noted that this year marks the 12th anniversary of the organization under its present name. The registry was originally formed as the Central Registry of Graduate Nurses 43 years ago.

The membership at the end of 1952 stood at 696, including 133 nursing assistants and 44 housekeepers. The number of doctors who took advantage of the telephone service offered by the registry showed considerable increase over the previous year. Other reports presented included: L. Gourlay, financial, credential and group effort committees; G. Shaver, education and public relations; Mrs. B. Buck, secretary.

The following are additional officers for the coming months: Vice-president, E. Anderson; secretary, F. Cripps; treasurer, I. Johnston. Private duty nurses included on the Board of Directors are: M. Butler, E. Anderson, A. Brady, A. Saunders, F. Meredith, and M. Scott.

General Hospital

Sr. St. Françoise de Chantal has been transferred to St. Joseph's Hospital, Sudbury, as superintendent of nurses. Sr. Madeline of Jesus has returned to O.G.H. from Lowell, Mass., to become director of nursing education at the University of Ottawa School of Nursing. Sr. St. Bertrand is taking a course in psychiatric nursing at the University of Toronto School of Nursing. On the completion of this course, she will return to O.G.H. to take the post of nursing supervisor of the newly opened psychiatry department which is under the direction of Dr. Karl Stern.

DISTRICT 9

SUDBURY

Sr. Melanie, chairman of Sudbury Chapter, presided at a regular meeting held at the General Hospital. Fifty members were present. Plans were made for the annual dinner at which the members of the graduating classes of St. Joseph's and the General hospitals will be guests. An interesting paper on "New Drugs" was given by Sr. St. Rose, pharmacist, St. Joseph's Hospital.

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PRINCE EDWARD ISLAND

The Association of Nurses of P.E.I. was very pleased to welcome Catherine Perkins, field representative and assistant editor of *The Canadian Nurse*, on her first visit to the province. In both Summerside and Charlottetown, district meetings were planned to coincide with her visit. Sessions were also held at the three hospitals and the subjects discussed included Rehabilitation, The Structure Study, Ward Organization and the Functions of the Head Nurse, The Nursing Course at the Toronto Western Hospital, Orientation, and Professional Nursing. The meetings were well attended by graduate and student nurses, Miss Perkins bringing a fresh viewpoint to her subject matter. Interest was shown by the discussions following her talks.

* * *

The annual meeting of the Community Nursing Registry, Charlottetown, was held recently when reports were given from the various committees. The registrar revealed that the number of active members was 38, a decrease of 11 from last year. The number of calls were 1,645, approximately 600 less than the previous year. The finance committee reported that $280 was raised from two White Elephant sales, two dances, and a rummage sale.

The officers for the coming year are: President, Mrs. G. MacKay; vice-president, Mrs. D. Corrigan; secretary, Mrs. M. MacDonald; treasurer, M. Archibald.

QUEBEC

MONTREAL

Children's Memorial Hospital

The following officers will serve during the coming months for the Staff Nurses' Association: President, E. McGlynn; vice-president, Mrs. N. Franklin; secretary, E. Braithwaite; treasurer, M. Woolley; educational convener, T. Potter; social convener, A. Coletta. The *Canadian Nurse* representative is J. Stunden.

The following nurses have been appointed to the staff: A. MacLennan, staff assistant; L. Holmes, A. Urquhart, to the O.R.; M. McNally, to the O.P.D. C. Mathews, after a leave of absence, is back with the O.R. B. Laurie has returned as medical ward secretary. After a course in O.R. administration at St. Michael's Hospital, Toronto, V. MacDonald has returned to take charge of the O.R. J. (Thirlaway) Marchuk has resigned as teaching supervisor, being replaced by T. Potter, a graduate of Victoria General Hospital, Halifax. J. (Brown) Sheilds, J. (Watters) Dwerryhouse, and N. (Forin) Clogg have also resigned.

Reddy Memorial Hospital

Mrs. R. Wolfson presided at a regular meeting of the alumnae association when plans were discussed for a square dance to be held in April. The members enjoyed the showing of a film entitled "Medicine in the Making."

G. Koivu, alumnae member, is welcomed back after taking a post-graduate course in psychiatry in Colorado. She is now on the staff of the Verdun Protestant Hospital.

Royal Victoria Hospital

Recent visitors to the hospital have been M. MacMillan and Mrs. A. (Jolliffe) Johnson. D. Dick is a member of the staff at the University of Manitoba School of Nursing Education. B. Pratt is with the Provincial Sanatorium, Charlottetown, P.E.I. C. McCallum and M. Coleman are at Goose Bay, Labrador. L. MacKenzie is in New York for further study leading to her M.A. M. Harling is in Penang, Malaya, with the General Hospital staff. I. Chittick is taking psychiatry at the University of Western Ontario. H. Rowe and M. Jardine are assistant head nurses at R.V.H.

QUEBEC CITY

Jeffery Hale's Hospital

Mrs. L. Teakle presided at the annual meeting of the alumnae association when 13

members were present. Plans were made for a rummage sale.

The following officers were elected to serve during the coming months: President, Mrs. Teakle; vice-presidents, M. Jones, Mrs. A. Seale; secretary, Mrs. F. Pugh; treasurer, A. MacDonald; councillors, G. Weary, Mmes R. Simons, Pugh, A. Myers. The following will also serve in various capacities: M. Dawson, E. Walsh, J. Radley-Walters, R. Perry, E. Fard, Mmes K. Baptist, C. Davidson, L. Kennedy, K. Nattress, D. Cormack.

SHERBROOKE

R. Sutton was elected president of the Sherbrooke Hospital Alumnae Association at the annual meeting. The vice-presidents are Mmes A. Lockley and J. Colton, with N. Beattie and Mrs. A. Savage serving as recording and corresponding secretaries respectively. The treasurer is Mrs. G. Bryant. Additional executive members are: V. Davies, Mmes N. Coates, G. Burt, and H. Leslie.

SASKATCHEWAN

CANORA

Irene Zylich is now superintendent of nurses at the Union Hospital, succeeding Mrs. L. Peever who has been acting in that position since last fall. A native of Virden, Man., Miss Zylich is a graduate of the Ontario Hospital, Whitby, with one year of affiliation at Toronto Western Hospital. She has served at the General Hospital, Virden, and also at the Whitby hospital as supervisor of a 95-bed ward. She has obtained her certificate in teaching and administration at the University of Toronto School of Nursing. Prior to taking up her post at Canora she was afternoon supervisor at Dauphin General Hospital, Man.

SASKATOON

St. Paul's Hospital

The Educational Lecture Program for graduate nurses began in January when Dr. Selinger gave a clinical demonstration on Mental Hygiene to students, head nurses, and supervisors. In February Dr. Hargarten spoke on "Social Hygiene Problems—Moral and Medical Questions Often Asked a Graduate Nurse."

Parents and friends of the September, 1952, class came to witness their "capping" in the hospital chapel, meeting afterwards for an entertainment and welcoming 36 new Freshmen B, including a student from Alabama.

Father Ehman, C.Ss.R., gave a talk on "Marriage—A Vocation" to the Sodality. The pre-lenten period ended with a St. Valentine Dance, a film show, and a Mardi Gras Bean Supper. Sr. Bezaire, superior, has returned from a mid-term conference in Chicago. She was guest speaker at the monthly supervisors' meeting.

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Asst. Supt. & Director of Nurses for 98-bed hospital, qualified to teach. 8-hr. day, 44-hr. wk. 1 mo. vacation. 14 days sick time after 1 yr. service. Apply, stating qualifications & references, Supt., Victoria Hospital, Renfrew, Ont.

Asst. Director of Nurses for 300-bed hospital to open in June. One qualified to teach & has held similar position before. Particulars on application to Mount Sinai Hospital, 100 Yorkville Ave., Toronto 5, Ont.

Clinical Instructors (medical & surgical). **Science Instructor. Operating Room Suture Nurses.** Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

Nursing Arts Instructor; Clinical Instructors in Medicine, Surgery & Pediatrics. Positions available this summer at Misericordia Hospital, Edmonton, Alta. Good personnel policies. 44-hr. wk. Address applications & requests for further information to Director of Nursing.

Instructors (2) (qualified)—Nursing Arts, Science. Good salary & personnel policies. Allowance paid for degree, if experienced. Apply Director of Nurses, General Hospital, Guelph, Ont.

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Public Health Nurses for York County Health Unit—generalized program. Proximity to Toronto permits possibilities of urban living conditions combined with rural work. Car provided. Health & accident insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Public Health Nurses for Oshawa Health Dept. Generalized urban service. 5-day wk. 1 mo. vacation. Minimum salary: $2,700. Transportation provided. Contributory P.S.I., Blue Cross & pension. Uniform allowance. Apply, stating experience & qualifications, Oshawa Board of Health, 65 Simcoe St. S., Oshawa, Ont.

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Registered Nurses (2) for General Duty immediately for modern 25-bed hospital. Salary: $170 per mo. plus full maintenance. 1 mo. holiday paid per yr. Increments & other benefits. Transportation refunded after 6 mos. duty. Apply Municipal Hospital, Two Hills, Alta. (Phone 335).

Registered Graduate Nurses. Salary: $210 with full maintenance or $250 with 1 meal while on duty. Uniforms laundered. 40-hr. wk. when staff complete. After 1 yr., 2 wks. vacation with pay; $75 bonus. 1¼ days sick leave per mo. Apply Superior, St. Ann's Hospital, Juneau, Alaska.

General Duty Graduate Nurses for 60-bed General Hospital, 150 miles northwest of Vancouver on B.C. coast. Salary: $222 per mo. less $25 for complete maintenance & laundering of uniforms. 4 wks. holiday with pay plus 10 statutory holidays. Transportation advanced if desired. Apply Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurse for 11-bed hospital in gold mining town in Cariboo. Salary: $185 plus full maintenance & laundry. 44-hr. wk. 1 mo. vacation. Excellent working conditions. Apply Matron, Gold Quartz Hospital, Wells, B.C.

General Duty Nurses for 77-bed General Hospital, 30 miles from New York City. Salary: $210-220 plus 2 meals & laundry. Living-in salary: $175-185 plus full maintenance. 3 wks. annual vacation. 12 days sick time. 7 paid holidays. 8-hr. day, 40-hr. wk. Also **Operating Room Nurses** at higher salaries. Apply Administrator, Ossining Hospital, Ossining-on-Hudson, New York.

Registered Nurse for General Duty for 45-bed hospital. Salary: $180 per mo. 8-hr. duty, rotating shifts. Complete maintenance in nurses' residence. 1 mo. vacation after 1 yr. service. 2 wks. sick leave per yr. Salary slightly lower for non-registered nurse. Apply Supt., Lady Minto Hospital, Chapleau, Ont.

Matron for active 20-bed hospital. Must be experienced in X-Ray work. Salary in accordance with qualifications. Apply Administrator, Terrace & District Hospital, Terrace, B.C.

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Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $83 plus Cost of Living Bonus of approx. $6.00 per wk. 44-hr. wk. For other perquisites & further information apply C. E. Brewster, Supt. of Nurses.

Graduate Floor Duty Nurses for Mount Hamilton Maternity Hospital, Hamilton, Ont. 44-hr. wk. Statutory holidays. Initial gross salary bi-weekly: $83 plus cost of Living Bonus. For other perquisites & further information apply Supt.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses for 611-bed General Hospital with School of Nursing. Salary: $273; increase $15 end of 1st yr.; $17 end 2nd & 3rd yr.; $19 end 5th yr. Differential of $10 for special services & p.m. & night duty. 40-hr. wk. 12 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Housing available. Apply Director of Nursing Service, General Hospital, Fresno, California.

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Registered Nurses for General Duty in 200-bed hospital in Niagara Peninsula. Gross salary: $210; afternoons, $220; nights, $215. Increments & return train fare after 12 mos. Also **Certified Nursing Assistants.** Salary: $160. 48-hr. wk.; no broken shifts. 21 days annual vacation. 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

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General Staff Nurses for 600-bed University Hospital. Openings in all services. Personnel policies meet approved minimum standards of North Carolina State Nurses' Ass'n. Salary: $180 per mo. with complete maintenance ($240 without maintenance). $20 additional for permanent evenings & nights. $120 annual increment for satisfactory service. 44-hr. wk. 24 days vacation the 1st yr., 30 days per yr. thereafter. Ill time allowance same as vacation. 6 holidays per yr. Exceptional opportunity for furthering education in Duke University. Write to Director, Nursing Service, Duke University Hospital, Durham, North Carolina.

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Registered Nurses for General Duty for Huntingdon County Hospital. This is a small General Hospital, in Town of Huntingdon, 45 miles southwest of Montreal, connected by excellent train & bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Two theatres, badminton club, skating, curling, dancing & only 8 miles from summer resort on Lake St. Francis. Salary: $140 per mo. with full maintenance with 3 increases of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. & 4 wks. holiday. Apply Mrs. B. Grant, Matron, County Hospital, Huntingdon, Que.

Supt. of Nursing for Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que. New hospital now under construction. Preference given to those possessing knowledge of French. Apply, stating experience & qualifications, to R.F. Stockwell, Q.C., P.O. Box 389, Cowansville, Que.

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• *Science Instructor* • *Junior Instructor*
• *Clinical Supervisor*

600-bed hospital. Over 200 students. Good Personnel Policies.
Positions open summer.

For information write to:

Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for large General Hospital. Openings available in all depts., including pediatrics & isolation, for nurses interested in permanent positions. Apply Director of Nursing, Victoria Hospital, London, Ont.

Graduate Nurses for modern, well equipped teaching hospital in central California. Salary: $273-320 per mo. 40-hr., 5-day wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

Graduate Nurses for General Staff for General Hospital, Parry Sound, Ont. (in the heart of tourist district). Salary: $145 for days; evenings $155 & nights $150 per mo. plus full maintenance in nurses' residence. 48-hr. wk. 2 wks. vacation plus 8 statutory holidays. Increment for first 2 yrs. Also **Charge Nurse for Obstetrical Unit.** Apply Director of Nurses.

Graduate General Duty Nurses for 35-bed General Hospital, 50 miles from Toronto. Gross salary: $200 per mo. for general duty. 44-hr. wk. 7 statutory holidays. 3 wks. annual vacation. 2 wks. sick time. Apply stating experience, Supt., Lord Dufferin Hospital, Orangeville, Ont.

Nurses (2) for modern hospital; nurses' home. Salary: $180 per mo. with full maintenance. Usual holidays with pay, sick leave, etc. Transportation one way refunded if stay 1 yr. Apply Matron, Union Hospital, Vanguard, Sask.

Registered Nurses for General Duty with opening of new wing of 70-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Banff & Calgary. Duties commence Apr. Salary: $155 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. 1 mo. holiday with pay plus statutory holidays each yr. 8-hr. day; 44-hr. wk. with rotating shifts. Apply Supt., Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty in active 22-bed hospital in Cariboo District, B.C. Salary: $200; $210 after 6 mos. Board & residence, $35. Transportation allowance up to $60 refunded after 1 yr. Full benefits of statutory holidays. Sick leave. 28 days vacation after 12 mos. or proportionate 6 mos. Apply Administrator, General Hospital, Quesnel, B.C.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $250 per mo. with advancement to $270; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

Registered Nurses for General Duty for small General Hospital. Salary: $140 per mo. with full maintenance. 6-day wk. 8-hr. duty, rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross paid. 10 days sick leave per yr. 6 statutory holidays. 28 days holidays. Apply Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for General Duty in 70-bed General Hospital in San Gabriel Valley, 40 min. from Los Angeles. Close to beaches & mountains. 40-hr. wk. 2 wks. paid vacation. 6 mos. increase in salary. Paid hospital insurance. Starting salary: $235 per mo.; $10 differential for afternoons & nights; $10 differential for surgery & maternity. Write for application form Supt. of Nurses, Inter-Community Hospital, Covina, California.

ANESTHESIA

A career specialty for the Graduate Nurse. **Eligibility:** Graduates of Accredited Schools of Nursing. **Course:** Study of the basic sciences related to Anesthesia. Clinical training in all phases of General Anesthesia, Resuscitation, and Inhalation Therapy. **Professional Opportunities:** Full-time position in teaching and non-teaching hospitals in United States. For special course write: **Mary H. Snively, R.N., In Charge of Nurses' Training Programs, Duke Hospital, Durham, North Carolina.**

Central Alberta Sanatorium, Calgary, Alberta, offers to Graduate Nurses a six-month Post-Graduate Course in Tuberculosis. Maintenance & salary as for General Staff Nurses. Opportunities for permanent employment if desired. Spring & Fall Classes. Further information on request.

Registered Nurses for Floor Duty. Also **Operating Scrub Nurse (1).** Modern 50-bed General Hospital with good working conditions & attractive salary. Apply Supt., District Memorial Hospital, Leamington, Ont.

Registered Nurses (4) to be in charge of 22-bed hospital while on duty. Salary: $13 per 8-hr. day. Apply Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Michigan.

Registered Nurses for General Floor Duty. Rotating shifts. Apply Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital commencing May. Apply, giving details of education, qualifications, experience, enclosing recent photo, Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Educational Director for School of Nursing of 200 students. Post-graduate experience preferred. For further information apply Director of Nursing, City Hospital, Saskatoon, Sask.

Asst. Supt. of Nurses by Sept. 1 for Provincial Mental Hospital, Ponoka, Alta. 1,450-bed active treatment hospital conducting an accredited School of Nursing. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications, experience & year of graduation, to Supt. of Nurses.

Operating Room & Maternity Nurses. Salary: $162.50 for recent graduates, 2 meals, laundry. 8-hr. day, 44-hr. wk.—straight shift. $15 differential evenings—$10 nights. Vacation, sick time & statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

Supervisor of Nurses for 80-bed hospital in Montreal. Good wages, nice working conditions, excellent prospects with this expanding, modern hospital. All applications strictly confidential. Apply, with full details, c/o Box N, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Matron by June for 30-bed hospital including new wing opening in May. Salary: $225 per mo. with $10 increase in 6 mos. 44-hr. wk. Statutory holidays. 3 wks. vacation with pay per yr. Separate nurses' home. Apply Sec., Municipal Hospital, Provost, Alta.

Graduate Nurses for Medical-Surgical Services & Obstetrics for General Duty. For further information apply Director of Nursing, Queen Elizabeth Hospital, 2100 Marlowe Ave., Montreal 28, Que.

Operating Room Nurses for new 40-bed Pediatric Hospital. Some experience required. 40-hr. wk. Starting salary: $275. Apply Director of Nurses, Mercy Hospital, Sacramento, California.

Floor Duty Nurses for 50-bed hospital on Lake Ontario, 65 miles from Toronto. 8-hr. duty. Salary: $190 per mo., living accommodation in residence. Apply Supt., Port Hope Hospital, Port Hope, Ont.

UNIVERSITY OF WESTERN ONTARIO SCHOOL OF NURSING

Offers the following programmes:

(1) A five-year basic programme leading to degree, *Bachelor of Science in Nursing.*
(2) One academic year of study and experience leading to Certificate in *Public Health Nursing.*
(3) One academic year of study and experience leading to Certificate in *Teaching and Supervision in Schools of Nursing.*
(4) Three months of study and experience in *Psychiatric Nursing.*
(5) A programme for graduate nurses, leading to *degree completion.*

For further information write to:

The Dean, School of Nursing, University of Western Ontario, London, Ontario.

Registered Nurse (qualified) immediately for General Hospital duty in 24-bed hospital, modernly equipped. Monthly salary: $165 less $15 room & board. Apply, stating experience & other information, to T. Stewart Cooper, Markdale, Ont.

General Duty Nurse for 107-bed modern hospital. Starting salary: $175 per mo. plus meals & laundry. Additional for each evening or night shift. Increases at 6 mos. & annually thereafter for further 2 yrs. 44-hr. wk. 8 statutory holidays. 21 days holidays with pay. Travelling expenses refunded after 6 mos. from point of entry into Ontario. Cumulative sick time. Medical & hospital plan subsidized. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Staff Nurses for new 200-bed Children's Orthopedic Hospital, Seattle, Washington. Unusual opportunities for employment in beautifully equipped, sparkling new hospital providing facilities for care of children in all pediatric specialties. Beginning salary: $235 per mo. with additional $10 for evening & night duty. 2 wks. vacation after 1 yr. 7 paid holidays per yr. 40-hr. wk. 12 days illness allowance per yr. cumulative to 36 days. Opportunities for promotion & varied experience. In addition, Seattle offers a mild year-round climate, all outdoor sports & unsurpassed scenery. For further information apply Director of Nursing.

General Duty Nurses (3). Commencing salary: $225; full maintenance $45 per mo. 44-hr. wk. 28 days annual leave plus 10 statutory holidays. Annual increases & sick leave. Fare advanced if desired. Apply Director of Nursing, General Hospital, Princeton, B.C.

Registered Nurses (2) immediately for 50-bed hospital in English-speaking community. Salary: $210 gross less $30 per mo. maintenance. $5.00 increase every 6 mos. for 2 yrs. 6-day, 48-hr. wk.—straight shifts alternating every 2 wks. 3 wks. sick leave & 1 mo. holiday with pay after 1 yr. service. Apply Matron, Union Hospital, Rosetown, Sask.

Nurses (2) for 12-bed hospital, 16 miles from Banff. Salary: $180 plus maintenance. 1 mo. holidays with pay. Sick leave allowed. Personnel policies as outlined by Alta. Ass'n of Reg. Nurses. Apply Matron, Canmore Hospital, Canmore, Alta.

Registered Nurses for positions in surgical & other wards in 2 large Manitoba Hospitals. Starting salaries: $200-220 per mo. with maximum up to $230. Comfortable staff quarters. Good hours & working conditions. Generous vacations, group insurance, all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Registered Nurses for 74-bed General Hospital. 44-hr. wk., rotating shifts. 1 mo. vacation per yr. Gross salary: $200 plus laundering of uniforms. $5.00 increases after 3 mos. 9 mos., 21 mos. later. Increment of $10 per mo. while on night duty & $15 per mo. while on evening duty. Residence accommodation available at hospital—$15 per mo. Meals available at hospital—30 cts. per meal. Apply Supt., General Hospital, Portage la Prairie, Man.

Licensed Practical Nurses for 74-bed General Hospital. 44-hr. wk., rotating shifts. Gross salary: $137.50 plus $5.00 increases after 3 mos., 9 mos. & 12 mos. satisfactory service. Increment of $10 per mo. for night duty & $15 per mo. for evening duty. Favorable personnel policies. Residence accommodation available. Apply Supt. of Nurses, General Hospital, Portage la Prairie, Man.

General Staff Nurses for medium sized hospital in Western Ontario. All depts. Good salary. All holidays & generous vacation. Living-in accommodation provided. Apply, by writing or in person, Director of Nursing, Memorial Hospital, St. Thomas, Ont.

POSITIONS VACANT

Graduate Nurses for general & tuberculosis work. **Night Supervisor. Nurse** to double as **asst. to Supt. of Nurses** & as operating room relief. **Nursing Attendants. Trained Nursing Orderlies. Stenographers (2). Lab. Technician**—all for Roseway Hospital, Shelburne, N.S. Application forms may be obtained from Nova Scotia Civil Service Commission, P.O. Box 943, Halifax, N.S. or by phoning 3-7341, Branch 230; or Dr. D.S. Robb, Medical Supt., Roseway Hospital, Shelburne, N.S.

Supervisor for 4-12 duty in active 50-bed hospital, near Toronto. 44-hr. wk. Desirable personnel policies. Salary: $220 per mo. if experienced. Living-in accommodation if desired. Apply, stating age, qualifications, experience & references, Supt., General Hospital, Cobourg, Ont.

General Duty Nurses (2) immediately for well equipped 12-bed hospital. 8-hr. shifts. Gross salary: $210 per mo. with full maintenance or $240 per mo. with maintenance available at minimal cost. Apply Superior, Notre Dame Hospital, Val Marie, Sask.

Public Health Nurses for Halton County Health Unit. Generalized program. Present minimum salary: $2,500 with adjustments for previous experience. Annual increment. Cumulative sick leave. 4 wks. vacation. Car allowance & loan if necessary for purchase of car. Apply Dr. A. G. Bull, Medical Office of Health, Halton County Health Unit, Milton, Ont.

Registered Nurses (2) for General Duty at 30-bed hospital in Dryden in northwestern Ontario, the heart of a tourist's paradise. Separate nurses' residence, fully modern. Salary: $160 per mo. plus full maintenance. Salaries subject to an annual increase. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

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Positions open for

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- **Staff Nurses**
- **Dietitian**

Apply to

Superintendent
PRINCE COUNTY HOSPITAL
Summerside, P.E.I.

• **WANTED** •

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Clinical Instructor in Pediatrics (1)
Nursing Science Instructor (1)
Clinical Instructor in Medicine (1)
Clinical Instructor in Obstetrics (1)

Duties to commence on

August 1st, 1953

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Apply:

Miss S. A. Davidson, Director of Nurse Education, McKellar General Hospital, Fort William, Ontario.